Connecticut Center for Natural Health

210 South Main Street, Middletown, CT phone: 860 347 8600 fax: 860 347 8434

New Patient Therapy Questionnaire

PLEASE DO NOT MAIL QUESTIONNAIRE. BRING IT WITH YOU TO YOUR APPOINTMENT.

Last Name _____ First _____ Middle Initial _____ Age _____

Date of Birth ____/____/____ NickName _____ Gender_____ Pronoun Preferred_____

Name of Parent or Legal Guardian (if under the age of 18):_____

Address:_____

City _____ State _____ Zip Code _____–_____

Home Phone _____ Cell Phone _____ Work _____

Social Security Number _____–_____–_____ Email _____

How did you learn about us: _____

Primary Care Physician: _____

Address: _____Phone_____ Fax_____

Are you covered by medical insurance? Yes or No If yes, who? _____

Is this your **"primary**" insurance coverage? Yes or No

Your Insurance ID # _____ Group Name or # _____

Secondary Insurance carrier if applicable:_____

Who's Name is the insurance in? (the subscriber) _____ ID# _____

Who will be responsible for payment of services not covered by insurance? _____

Name of spouse, parent, relative, friend, or significant other _____

Emergency Contacts :

Name:	**Relationship:**	**Phone:**
1._____	_____	_____
2._____	_____	_____
3._____	_____	_____

_____ _____ _____

Signature: Patient/Parent /Legal Guardian Print: Patient/Parent/Legal Guardian Date: