Aveda Integrative Medical Center
WELCOME TO MY PRACTICE
NEW PATIENT REGISTRATION FORM

Today's Date			
PATIENT INFORMATION			
First Name	**Middle Name**	**Last Name**	
Date of Birth	**Social Security Number**	**Occupation**	
Preferred Language	**Race**	**Ethnicity**	
Street Address	**City , State , Zipcode**		
Home Phone #	**Cell Phone #**	**Work #**	
Email Address	**Would You Like to Receive Emails From Dr.Saxena ? (Pls Circle One)**	**YES NO**	**Initial**
How Did you hear about Dr.Saxena's Clinic ?			
Other family members seen here :			
PAYMENT INFORMATION			
Person Responsible for the bill	**Birth Date**	**Address (if different)**	**Phone #**
Credit Card Type	**Credit Card Number**	**Social Security Number**	**Expiration Date**
Bank Issued the Card			
Patient's relationship to responsible person			
IN CASE OF EMERGENCY			
Name of local friend or relative (not living at the same address)	**Relationship to patient**	**Home Phone Number**	**Cell phone number**
Address			

The above information is true to my knowledge. I consent to the treatment and/or procedure(s) necessary for the above named patient. My signature on this form acknowledges that I agree to bear full financial responsibility for all services provided that may include supplements and/or lab testing ordered by Dr. Saxena. By signing this registration form, I consent to the use and disclosure of my/patient's protected health information for the purposes of treatment, payment, and healthcare operations. I acknowledge the receipt of the Dr. Saxena's Notice Of Privacy Practices. Also, by signing, I have read and fully understand the above consent of treatment and financial responsibility.

Signature of Patient or Parent/Guardian _____ Full Name of the Person Signing _____ Date _____