

MARIO ROXAS, ND  
Naturopathic Physician

604 N Fifth Avenue • PO Box 1189 • Sandpoint, ID 83864  
P: 208.946.0984 • F: 208.246.4995 • E: AskDrRoxas@gmail.com  
www.DrRoxas.com

## PATIENT REGISTRATION FORM

### patient information

last name: \_\_\_\_\_ first name: \_\_\_\_\_ middle initial: \_\_\_\_\_  
address: \_\_\_\_\_  
city: \_\_\_\_\_ state: \_\_\_\_\_ zip: \_\_\_\_\_  
phone: ( \_\_\_\_\_ ) \_\_\_\_\_ 2<sup>nd</sup> phone: ( \_\_\_\_\_ ) \_\_\_\_\_  
birth date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ age: \_\_\_\_\_ sex: male \_\_\_\_\_ female \_\_\_\_\_  
social security no: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ marital status: single \_\_\_\_\_ married \_\_\_\_\_ divorced \_\_\_\_\_

### responsible party/guarantor

last name: \_\_\_\_\_ first name: \_\_\_\_\_ middle initial: \_\_\_\_\_  
address: \_\_\_\_\_  
city: \_\_\_\_\_ state: \_\_\_\_\_ zip: \_\_\_\_\_  
phone: ( \_\_\_\_\_ ) \_\_\_\_\_ social security no: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
relationship to patient (please circle one):      self      spouse      child      other

### employment information

employer: \_\_\_\_\_ job title: \_\_\_\_\_  
address: \_\_\_\_\_  
city: \_\_\_\_\_ state: \_\_\_\_\_ zip: \_\_\_\_\_  
phone: ( \_\_\_\_\_ ) \_\_\_\_\_ ext \_\_\_\_\_

### primary insurance company

company: \_\_\_\_\_ phone: ( \_\_\_\_\_ ) \_\_\_\_\_  
policy holder: \_\_\_\_\_ relationship (please circle one):  
policy no: \_\_\_\_\_ self      spouse      child      other  
group no: \_\_\_\_\_  
address: \_\_\_\_\_  
city: \_\_\_\_\_ state: \_\_\_\_\_ zip: \_\_\_\_\_  
type of injury: work claim no: \_\_\_\_\_, auto \_\_\_\_\_, personal injury \_\_\_\_\_

### how did you hear about us?

doctor/therapist: \_\_\_\_\_ ref no: \_\_\_\_\_ phone: ( \_\_\_\_\_ ) \_\_\_\_\_  
print advertisement: \_\_\_\_\_ internet: \_\_\_\_\_  
friend/relative: \_\_\_\_\_ other: \_\_\_\_\_

I hereby authorize Mario Roxas, ND and the independent doctor or therapist to furnish the insured's insurance company all information which said insurance company may request concerning my presenting illness or injury. I hereby assign to said doctor or therapist all money to which I am entitled for health expenses relative to the services performed from time to time. I understand I am financially responsible for any and all charges.

  X    
patient/guardian signature

\_\_\_\_\_  
date