Yellow Pine Naturopathic Clinic

Dr. Margaret Coffey, ND
406-351-0131
www.yellowpineclinic.com

Personal Information

All provided material is protected as confidential.

Please fill in information or circle choices as appropriate:

Name: _____ Date of birth: _____

Preferred name: _____ Previously used names: _____

Gender: Male Female Other: _____

Address: _____
(Number and Street) (City) (State) (Zip)

Cell phone: _____ May we leave you a message? Yes No

Work phone: _____ May we leave you a message? Yes No

Home phone: _____ May we leave you a message? Yes No

Which phone do you prefer we use? _____

Email: _____ May we email you? Yes No
(Email correspondences are not considered confidential communications)

Name of Parent/Guardian (if under 18): _____

Emergency Contact: _____ Relation: _____ Phone: _____

Preferred pharmacy: _____

Insurance: _____

How did you hear about us?_____

Consent for Treatment

I am requesting and hereby authorize services offered to me by Yellow Pine Naturopathic Clinic (Dr. Margaret Coffey), including physical examination and treatment deemed appropriate by my provider. As a patient, I am to be fully informed of benefits and possible complications, as well as alternatives to the proposed treatment, including no treatment. I understand that I am responsible for all fees at the time of service, regardless of insurance coverage or treatment outcome. I recognize that the doctor is a licensed Naturopathic Physician in the State of Montana, and that she has been trained to act on my behalf as a primary care, general practice physician.

Yellow Pine Naturopathic Clinic requires 24 hr cancellation notice for appointments. Fees apply for late cancellations. I confirm that I have read and fully understand the above prior to signing.

Signature of Patient (or Guardian): _____ Date: _____