Patient Information

Thank You For Helping Streamline the Registration Process!

First Name: ____________________________ **Last Name:** _____________________________ **Middle Initial:** ________

Date of Birth: ___________________ **Gender:** ________

Address: ____ **City:** _______________________________

State: ________ **Zip:** ______________

Cell Phone: (   ) ____________________ **Work Phone: (   )** _____________________

Landline: (   ) __________________________

Email: ____ **May we send newsletters to you by email?** ○ ***No*** ○ ***Yes***

Whom may we thank for referring you? ____

Insurance Information

Name of Insured: ____ **Relationship to Patient:** __________________

Birthdate: ______________________ **Insurance Company:** ____

ID Number: ____ **Group:** _____________________________________

Next of Kin

Name: ____ **Relationship to patient:** ______________________________

Address: ____ **Home Phone:** __________________________

Cell Phone: _________________________ **Email:** ________________________________

Responsible Party (Complete if someone other than patient is responsible for account)

Name: ____ **Relationship to patient:** ______________________________

Address: ____ **Home Phone:** __________________________

Cell Phone: _________________________ **Email:** ________________________________

Dr. Jonathan Goodman, N.D

5 Maple Street Bristol, CT 06010

(860) 584-5746 • (860) 584-5748

drgoodmannd@gmail.com

CREDIT CARD ON FILE POLICY

We require keeping your credit or debit card on file as a convenient method of payment for the portion of services that your insurance doesn't cover, but for which you are liable.

Your credit card information is kept confidential and secure and payments to your card are processed only after the claim has been filed and processed by your insurer, and the insurance portion of the claim has paid and posted to the account. Your card will also be used to pay for no-shows and late cancellations, per office policy. When you make your first appointment, we will authorize a deposit of $90 to secure your place in the schedule. This amount will not be charged unless there is a no-show.

I authorize Dr. Jonathan Goodman, ND to charge the portion of my bill that is my financial responsibility to the following credit or debit card:

☐**Amex** ☐**Visa** ☐**Mastercard** ☐**Discover**

Credit Card Number ____

Expiration Date _____/______/ ______

Cardholder Name ____

Signature ____

Billing Address ____

City_____________________**State**_______**Zip** ____________

I (we), the undersigned, authorize and request Dr. Jonathan Goodman, ND to charge my credit card, indicated above, for balances due for services rendered that my insurance company identifies as my financial responsibility.

This authorization relates to all payments not covered by my insurance company for services provided to me by Dr. Jonathan Goodman, ND.

Patient Name (Print): ____

Patient Signature: ____

Date: _____/ _____/ ______