

**Blackbird Clinic** PLLC  
 Naturopathic & Nutritional Medicine  
 214 Pine St./ PO Box 1039 Okanogan WA 98840  
 Phone: (509) 422-3700

Patient Information Form		Please Complete All Entries		
<u>Adult</u> Patient Name (Last-First-Middle) or Parent/Guardian of minor):	Sex: M _____ F _____	Date of Birth:	Age:	Ethnic origin(s), as specific as possible:
<u>Minor</u> or Dependent Patient Name (Last-First-Middle):	Sex: M _____ F _____	Date of Birth:	Age:	Ethnic origin(s), as specific as possible:
Mailing Address:  Street:  City and State:  Zip:	Marital Status:      Single _____      Married _____  Divorced _____      Life Partner _____      Widowed _____			
Email Address:	Home Phone Number: (      )			
Name of Employer:	Cell Phone Number: (      )			
Employer Address (Street-City-State-Zip):	Work Phone:			
Name of Spouse (Last-First-Middle):	Occupation:			
Spouse's Employer:	Spouse's Work Phone Number:			
Name (in case of emergency):	Emergency Phone Number:			
Whom may we thank for referring you to us/ How did you hear about us?	Phone Number:			
Primary Care Physician:	Phone Number:			
Who is financially responsible for Payment:	I will be paying today by: Check _____ Cash _____ Visa _____ MC _____			

I Undersign and Agree that I am Ultimately Responsible for Payment at Time of Service.  
 I Certify this Information is True and Correct to the Best of my Knowledge.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Print Name: \_\_\_\_\_