Pacific Integrative Oncology

CONTACT INFORMATION

Name: ____________________________________ Date of Birth: ______________ Age: _____

First MI Last

Street Address: ______________________________________ City: _______________________

State: _____ Zip code: ___________ Gender: _____ Home Phone: ________________

Cell Phone: __________________ How did you hear about us? __________________________

Email: ____

INSURANCE INFORMATION

Carrier: __________________________ Subscriber ID: ________________________

Group #: ________________ Naturopathic Coverage? (Y/N) _________ Copay: ___________

MEDICAL HISTORY

What will we be seeing you for? ____

What treatments have you tried so far? ____

Primary Care Provider: _________________________________ Phone: ____________________

Other providers (i.e. Specialists): ____

Do you have any drug allergies? __________________________ Pharmacy: _______________

Please list all supplements and prescriptions you currently take:

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____
____

Is there any additional information you would like Dr. Niesley to know?:

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____

What are your goals for meeting with Dr. Niesley?:

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