Bedford Natural Medicine
169 South River Road Unit 4 Bedford, NH 03110
Phone: (603) 262-1939 Fax: (603) 294-1594

Patient Information Form

Last ______________________________ First ____________________________ Middle _____________________________
Date of birth________________ Gender_______ Nickname, preferred name______________________________________
Address___________________________________ City_______________________ State________ Zip________________
SS#________________Home Phone_____________________Work hone___________________Cell_____________________
May we leave confidential voice mail message for you at any of the above numbers? Home____Work____Cell______
EMAIL ADDRESS (if okay for communication purposes)____

Employer/School_________________________________
Mothers name (minors only)__________________________ Fathers name (minors only)____________________________
Emergency contact name______________________________ Contacts phone number_______________________________
Relationship to emergency contact______________________ Do you have special needs?____________________________

How did you hear about my office?____

Guarantor Information

This section must be completed if someone other than the patient is financially responsible for the patients account
Last name________________________First name____________________________Middle name______________________
Address__________________________________City________________________State__________Zip_________________
Phone___________________________Date of birth___________________SS#_______________________Gender________
I hearby acknowledge that I am financially responsible for payment of all services rendered to the above named patient and that I am subject to all financial terms listed below.

X____ ______________________________
Guarantors signature required Date

Terms of Admission

Financial terms: I understand that there is a cancellation policy and that I may be billed for the full rate of the missed appointment if cancelled with less than 24 hours notice. I understand that services rendered are to be paid in full at the completion of the office visit. I understand any guarantor listed above is subject to the same financial terms as outlined above and that my payment history, account balance, may be disclosed to the guarantor for the purposes of securing payment. I understand if the guarantor, if someone other than myself, is not authorized to receive my medical information unless expressly authorized by me in writing.

Privacy terms: I keep a record of healthcare services provided to you. Applicable state and federal laws protect confidentiality of your medical records and grant you the right to see or obtain a copy of the record we keep. Moreover, if you believe that information in your record is inaccurate, you may also request that we correct or amend that record. I will not disclose your medical information to others unless you direct us to do so or applicable laws authorize us to do so. If you have questions concerning the management of your healthcare information , wish to require about your rights or if you wish to make an appointment to review your medical record, please do so.

I hearby acknowledge that I have read the above information, should I fail to sign this form, I acknowledge that Bedford Natural Medicine has made a good faith effort to obtain my acknowledgement

X____ ___________________________________
Patients signature Date
X____ ___________________________________
Guardian/Representative Signature and relationship Date

Dr. Kristen O'Dell