Natural Health Partners
1403 Lomita Blvd., Suite 303-B
Harbor City, CA 90710
(310) 988-8403
Fax (310) 634-0389

Intake Form

Name: _____ **Date**: _____

Age: _____ **Sex**: _____ **Date of Birth**: _____

Address: _____ **City**: _____ **Zip**: _____

Day Phone: _____ **Evening Phone**: _____ **Cell Phone**: _____

Work Phone: _____ E-Mail: _____

- ☐ **Married**
- ☐ **Divorced**
- ☐ **Widowed**
- ☐ **Single**
- ☐ **Separated**

Occupation: _____

Employer: _____

Address: _____

Reason for your appointment today: _____

In Case of Emergency, Please Notify: _____ **Phone**: _____

Payment Information: I will be paying by:

Cash _____
Personal Check _____
Credit Card:

- ☐ **VISA & MasterCard**
- ☐ **Discovery**

How did you hear about us?

- ☐ **Referral Who referred you to our clinic? _____**
- ☐ **Internet If so, which website? _____**
- ☐ **Media (TV, newspaper, magazine) If so, please identify: _____**
- ☐ **Flyer**
- ☐ **Lecture**
- ☐ **Conference or Health Expo**
- ☐ **Other Please explain: _____**