

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: _____