Patient Information

Thank You For Helping Streamline the Registration Process!

First Name: _____Last Name:_____ Middle Initial: _____

Date of Birth: _____ Gender: _____

Address: _____ City: _____

State: _____ Zip: _____

Cell Phone: ( ) _____ Work Phone: ( )_____

Landline: ( )_____

Email: _____ May we send newsletters to you by email? ○ *No* ○ *Yes*

Whom may we thank for referring you? _____

Insurance Information

Name of Insured: _____ Relationship to Patient: _____

Birthdate: _____ Insurance Company: _____

ID Number: _____ Group: _____

Next of Kin

Name: _____Relationship to patient: _____

Address: _____ Home Phone: _____

Cell Phone: _____ Email: _____

Responsible Party (Complete if someone other than patient is responsible for account)

Name: _____Relationship to patient: _____

Address: _____ Home Phone: _____

Cell Phone: _____ Email: _____

Dr. Jonathan Goodman, N.D
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(860) 584-5746 • (860) 584-5748
drgoodmannd@gmail.com

CREDIT CARD ON FILE POLICY

We require keeping your credit or debit card on file as a convenient method of payment for the portion of services that your insurance doesn't cover, but for which you are liable.

Your credit card information is kept confidential and secure and payments to your card are processed only after the claim has been filed and processed by your insurer, and the insurance portion of the claim has paid and posted to the account. Your card will also be used to pay for no-shows and late cancellations, per office policy. When you make your first appointment, we will authorize a deposit of $90 to secure your place in the schedule. This amount will not be charged unless there is a no-show.

I authorize Dr. Jonathan Goodman, ND to charge the portion of my bill that is my financial responsibility to the following credit or debit card:

☐**Amex** ☐**Visa** ☐**Mastercard** ☐**Discover**

Credit Card Number _____

Expiration Date _____/_____/ _____

Cardholder Name _____

Signature _____

Billing Address _____

City_____**State**_____**Zip** _____

I (we), the undersigned, authorize and request Dr. Jonathan Goodman, ND to charge my credit card, indicated above, for balances due for services rendered that my insurance company identifies as my financial responsibility.

This authorization relates to all payments not covered by my insurance company for services provided to me by Dr. Jonathan Goodman, ND.

Patient Name (Print): _____

Patient Signature: _____

Date: _____/ _____/ _____