SUBMIT FORM

Center for Natural Medicine P.A.

902 East Second St, Suite 325
Winona, MN 55987

507–452–6640 Office
507–452–6646 Fax
www.tcfnm.com

Registration Form

Welcome to the Center for Natural Medicine, P.A. and thank you for choosing us to be a part of your healthcare team.

First Name:	Middle Initial:	Last Name:	Date of Birth:	
Address:		City:	State:	Zip:
Email:		Number of Children:	Ages:	
Status: ☐ Single ☐ Married ☐ Widowed		Name of Spouse:		
		Anniversary:		

EMPLOYMENT INFORMATION

	You	Your Spouse (or Parent*)
Employer		
Occupation		
Work Phone		

PHYSICIAN INFORMATION

Name of Your Family Physician:
Address:
☐ MD ☐ DO ☐ DC ☐ Specialist ☐ Other:

How would you prefer we contact you? ☐ Home ☐ Cell ☐ Work # _____

Who may we thank for referring you? _____

May we send them a thank you with your first name on the card? ☐ Yes ☐ No
If yes, please type your initials here: _____

*FOR MINORS

Please complete parent's Employment Information on Spouse section above.

Parent's Name:	Phone:		
Address:	City:	State:	Zip:

OUR PERSONAL CONCERN

Our personal and professional concern is with just two things, **your health and our reputation!** Therefore, we accept only those as patients whom we believe we can help. After the doctor evaluates your history, physical and laboratory findings, you can be sure that holistic natural healthcare is a viable treatment option for your condition.

Fees are payable when service is received.