Laurie Marzell, N.D., N.C.M.P.

15962 Boones Ferry Rd #102, Lake Oswego, OR 97035 ♦ Phone: 503-655-9493 ♦ Fax: 503-699-1847

PATIENT INFORMATION Date: _____

Name: _____ Birthdate: _____ Age: _____

Gender (Please circle one): M / F Marital Status (Please circle one): Single / Married / Divorced / Widowed

Address: _____ City: _____ ST: ____ Zip: _____

Phone #'s: _____ Email: _____

By filling out my email address, I consent to receiving emails for upcoming appointment reminders and clinic news/updates.

Employer: _____ Occupation: _____

Referred by: _____

RESPONSIBLE PARTY IF OTHER THAN ABOVE

Name: _____ Birthdate: _____ Age: _____

Address: _____ City: _____ ST: ____ Zip: _____

Phone #'s: _____ Email: _____

INSURANCE INFORMATION

Insurance Company Name: _____

Address: _____ City: _____ ST: ____ Zip: _____

ID #: _____ Group #: _____ Phone #: _____

Policyholder Name: _____ Birthdate: _____

Gender (Please circle one): M / F Relationship to Policy Holder (Please circle one): Self / Spouse / Child

EMERGENCY CONTACT INFORMATION

Name: _____ Relationship: _____ Phone #: _____

"I certify that the above information is true and accurate to the best of my knowledge. By signing below I am giving my consent and/or permission to Dr. Laurie Marzell and her healthcare staff to perform reasonable and necessary medical examinations, testing and treatment."

Signature: _____ Date: _____