

Harmony In Health Medical Center  
14300 N Northsight Blvd, Suite 108  
Scottsdale, AZ 85260  
480-659-6030  
480-588-7903(Fax)  
Kathy Kamin N.D.

CONFIDENTIAL PATIENT INFORMATION  
PLEASE FILL IN ALL PORTION OF THIS FORM. IF YOU NEED HELP, PLEASE ASK

Date of Information: \_\_\_\_\_ Email Address \_\_\_\_\_

Name of Patient: \_\_\_\_\_ Age: \_\_\_\_\_ Martial Status: \_\_\_\_\_

Permanent Address: \_\_\_\_\_ Apt # \_\_\_\_\_ City \_\_\_\_\_ State: \_\_\_\_\_ Zip \_\_\_\_\_

Temporary Address: \_\_\_\_\_ Apt # \_\_\_\_\_ City \_\_\_\_\_ State: \_\_\_\_\_ Zip \_\_\_\_\_

Phone  
(home)(\_\_\_\_\_) \_\_\_\_\_ (cell)(\_\_\_\_\_) \_\_\_\_\_ (work)(\_\_\_\_\_) \_\_\_\_\_

SS# \_\_\_\_\_ Birth date: \_\_\_\_\_ Sex \_\_\_\_\_

Occupation \_\_\_\_\_ Employed by \_\_\_\_\_

Work Address: \_\_\_\_\_ City \_\_\_\_\_ State: \_\_\_\_\_ Zip \_\_\_\_\_

Name of nearest relative not living with you \_\_\_\_\_ phone: (\_\_\_\_\_) \_\_\_\_\_

Name of spouse (or parent for minor child) \_\_\_\_\_ SS# \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_ Work# (\_\_\_\_\_) \_\_\_\_\_

Who may we contact in case of an emergency? \_\_\_\_\_

CLINIC POLICY REQUIRES PAYMENT AT TIME OF SERVICE. I WILL BE PAYING TODAY BY:

CASH \_\_\_\_\_ CHECK \_\_\_\_\_ VISA \_\_\_\_\_ MASTERCARD \_\_\_\_\_ AMEX \_\_\_\_\_

Chase Financing (special pricing not included) \_\_\_\_\_

Driver's License # \_\_\_\_\_ Exp date \_\_\_\_\_

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Parent or Guardian Signature

\_\_\_\_\_  
Date