Dr. Kenzie Maloy, DC, DABCI, DACCP, DACBN
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Hermiston, OR 97838
Phone: 541-371-3700
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Patient Name: _____ Date of Birth: _____ Male ☐ Female ☐

Address: _____

Preferred Phone #: _____ Home ☐ Work ☐ Cell ☐ Marital Status: _____

Preferred Language: _____ Have you traveled outside of the USA recently: Yes ☐ No ☐

Employer: _____ Full Time ☐ Part Time ☐ Unemployed ☐ Retired ☐

Is this work related: Yes ☐ No ☐ If yes, date of injury _____

Is this related to an auto accident: Yes ☐ No ☐ If yes, date of accident: _____

If patient is a child, with whom does the child reside? Mother ☐ Father ☐ Both Parent ☐ Guardian ☐
** **Guardianship papers or verbal parental permission is required prior to examination if parent is not present**

| **GUARANTOR INFORMATION** | | |
|---|---|---|
| Guarantor name: | DOB | Male ☐ Female☐ |
| Guarantor address: | | |
| Telephone | Employer | Work Phone |
| **INSURANCE INFORMATION** | | |
| **PRIMARY Insurance Name:** | | |
| Subscriber name | DOB | Male ☐ Female ☐ |
| Subscriber address | | |
| Telephone number: | Relationship: Self ☐ Spouse ☐ Child ☐ Other, explain other: | |
| Policy #: | Group/Member # | |
| **SECONDARY Insurance Name:** | | |
| Subscriber name | | |
| Subscriber address | | |
| Telephone number: | Relationship: Self ☐ Spouse ☐ Child ☐ Other, explain other: | |
| Policy #: | Group/Member # | |
| **EMERGENCY CONTACT INFORMATION** | | |
| Name: | Telephone: | Relationship: |

*I hereby authorize payment directly to Pinnacle Natural Health Center for insurance benefits. I understand I am financially responsible for all services rendered to the patient. Patient balances are to be paid at the time of service. I hereby give my express written consent to Pinnacle Natural Health Center and any of it's agents to communicate with me regarding my account(s) through various means of communication including but not limited to (1) cellular phone, landline, text or similar electronic devices. This express consent is given in order to permit Pinnacle Natural Health Center to more easily communicate with regarding any issue; including for purposes of billing, insurance and collection of any balance due.*

Signature: _____ Date: _____