

Naturopathic Family Healthcare

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Name: _____ Date of Birth: _____ SSN: _____

Address: _____ Phone Number: _____

_____ Email Address: _____

Occupation: _____ Employer: _____

Spouse or Partner's Name: _____

Contact in case of emergency:

Name: _____

Relationship: _____

Phone number: _____

Alternate Phone number: _____

Check here if we can leave a message at phone number given

Check here if you permit us to use your email address for correspondence (will not be used by anyone but Naturopathic Family Healthcare)

Check box if you would like to receive newsletters with health information

How did you hear about Naturopathic Family Healthcare:

Internet

Lecture

Yellow Pages

Affiliation of SCNM

A Patient: _____ Other: _____