

PATIENT INFORMATION

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Date _____

Name _____

Address _____

City _____ State _____ Zip _____

Sex: M F Age _____ Birthdate _____

Single Married Significant Other
 Widowed Separated Divorced

Patient SS# _____

Occupation _____

Employer _____

Emp. Address _____

Emp. Phone _____

Spouse/Partner's Name _____

Birthdate _____ SS# _____

Occupation _____

Spouse/Partner's Employer _____

Whom may we thank for referring you? _____

PHONE NUMBERS

H _____ W _____ Cell _____

Best time & place to reach you _____

IN CASE OF EMERGENCY, CONTACT

Name _____ Relationship _____

Home phone _____ Work phone _____

GENERAL INFORMATION

Have you had acupuncture before? Yes No

Have you used Chinese herbal medicine? Yes No

Are you currently under the care of a physician? Yes No If Yes, for what? _____

Physician's name: _____

Physician's phone: _____

INSURANCE

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? Yes No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage with _____ and assign directly to

_____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the provider to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature _____

Relationship _____ Date _____

ACCIDENT INFORMATION

Is condition due to an accident? Yes No

Date _____

Type of accident Auto Work Home Other

To whom have you made a report of your accident?

Auto Insurance Employer Worker Comp. Other

Attorney Name (if applicable) _____