Patient Information

PATIENT INFORMATION

Date: _____

Name: _____
First M.I Last

Address: _____

City State Zip

Primary

Phone: ☐ Home: _____

☐ Cell: _____

☐ Work: _____

IN CASE OF EMERGENCY, CONTACT:

Name: _____ Relationship:_____

Home Phone:_____

Work Phone: _____

How are you paying for this appointment?

☐ Insurance OR ☐ Self-Pay

D.O.B. _____ Age: _____

SS #: _____ Sex: ____M ____F

Marital Status: _____Single ____Married ____Other

Occupation: _____ ☐Student

Spouce/Partner Name: _____

Occupation: _____

Employer: _____

Whom may we thank for referring you?

Email address (for appt. reminders)

INSURANCE

Insurance Co.: _____

Patient Relationship to Insured:

☐Self ☐Spouse ☐Child ☐Other

Insured's I.D.#: _____

Employer's Name/School Name:

Is there any other health benefit plan?

☐ Yes ☐No

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 all 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 inormation 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 reported this accident?

_____Auto Insurance _____Employer _____Work Comp. _____Other

Attorney Name (If applicable) _____

GENERAL INFORMATION

Have you had acupuncture before? ____ Yes ___No

Have you ever used Chinese herbal medicine? ___Y ___N

Are you currently under the care of a physician? ___Yes ___No

If yes, for what?_____

Physician's Name: _____

Phone: _____