



# The Acupuncture Clinic

Jayne Sontag, L.Ac.

907-748-5895

www.AlaskaAcupunctureClinic.com

Patient Legal Name: \_\_\_\_\_

Nickname/ **preferred name**: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Parent/Guardian name: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Parent/Guardian telephone or number: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Physical Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Preferred Contact Phone:  Home  Work  Cell

Emergency Contact: Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Emergency Contact Phone Number: \_\_\_\_\_

How did you hear about us?: \_\_\_\_\_

Are you a veteran?  Yes  No (**Veteran only**) Social Security Number: \_\_\_\_\_

The above information is true to the best of my knowledge. It also authorize Jayne A. Sontag L.Ac. Dba The Acupuncture Clinic or insurance company to release any information required to process my claims.

\_\_\_\_\_  
Patient/Guardian Signature

\_\_\_\_\_  
Today's Date