Patient Information

Please help us provide you with a complete evaluation by taking the time to fill out this questionnaire. All your information will be confidential. If you have questions, please ask. Thank you.

Patient Name: ______________ ______________ ______________ Date: _________

First Middle Last

DOB: ___/___/___ Age: ______ Sex: M F Marital Status: Married Single Divorced

Height: ________Feet _________Inches Weight: _________lbs.

Address ________________________________City_________State_______Zip Code________

Phone Numbers: H-(____)______________W-(____)_____________C-(____)___________

SSN: __________________________ Email:__________________________

Employer_________________________________ Occupation__________________________

Employer Address____

If Minor, Responsible Party____

How did you find us? Dr._____________ / Patient _______________ / Online / Insurance

Do you have Health Insurance? Y/N, Name of Insurance Company:_________________

Does your insurance cover acupuncture? Y/N

Have you ever been treated by acupuncture? Y/N

Do you have a pace maker? Y/N

Do you have a bleeding disorder? Y/N

Emergency Contact Information

Emergency Contact Name ___________________Relationship to Patient_______________

Phone Numbers: H-(____)___________W-(____)_____________C-(____)___________

Emergency Contact Name ________________Relationship to Patient _______________

Phone Numbers: H-(____)___________W-(____)_____________C-(____)___________

Insurance Information

In the event that insurance providers will pay for acupuncture, I am requesting this information. Please fill out as much as you are comfortable with.

Were you injured? Y/N Date of Injury___________Auto/Work Comp/ Other (Circle)

Insurance Company:________________Group #:____________ID/Claim #:__________

Policy Holder' Name:_________________ DOB: ___/___/___Phone #:______________

Address:____

*****Please provide a copy of the front and back of your Insurance Card*****