

PATIENT INFORMATION (Please print)

Patient File #: _____

Last Name: _____ First Name: _____ Middle Initial: _____

Birth Date: _____ (_____) Gender: M F Marital Status: M S D W other
MM-DD-YY Age

Mailing Address: _____
Street City State zip

Phone #: H () _____ O () _____ C () _____

Email Address: _____ How you heard about us? _____
(Please specify the name of referral, internet or yellow book if possible)

Emergency Contact: Name: _____ Relationship: _____ Phone #: _____

Occupation: _____ Employer: _____

Employer address: _____
Street City State zip

PLEASE READ AND SIGN

I take full responsibility for any and all charges for services performed by Hsiao-Lan Chung, Dipl. Ac., OMD, regardless if I have insurance coverage or not. I realize full payment (or co-pay) for all services is due at the time the services are rendered. I have read and understand the office policy of the Chernly and Chung Acupuncture Center, Inc and C & C Wellness Center, Inc.

If I am or become an insurance patient, I authorize the release of any medical records necessary to process any insurance claims and to process any auto accident claims or to give a progress report to any referring physician on my behalf. I authorize payment of medical benefits to Hsiao-Lan Chung /Acupuncture Center, Inc. or Hsiao-Lan Chung/C & C Wellness Center, Inc. for the services described on any processed insurance claims for recorded dates of service. I am personally aware of and responsible for the status of my insurance eligibility and benefits regardless of the source of those insurance benefits. If for any reason the insurance company does not pay for services performed, I assume full responsibility for all outstanding bills and will pay any balance due to Hsiao-Lan Chung /Acupuncture Center, Inc. or Hsiao-Lan Chung/C & C Wellness Center, Inc.

Yes, all information provided is true, correct and complete to the best of my knowledge.

Patient/Guardian name print Patient/Guardian Attest Date

INSURANCE INFORMATION

Insurance Company: _____ Group/Plan # _____ Effective Date: _____

Insured's Name: _____ Your relation to Insured: self spouse child other

Insured's Address if different from above: _____

Insured's ID/SS# _____ Insured's Birth Date: _____ Insured's Phone: _____

Insured's Gender: M F Insured's Employer: _____

Is this insurance: () group plan () TWCC () auto () other (explain) _____

If auto accident/ injury: Claim # _____ Date of injury _____

Secondary Insurance Company _____ ID/SS# _____

Secondary Insured's Name: _____ Date of Birth (MM-DD-YY) : _____

MEDICAL HISTORY

Patient Name: _____

Height: _____ ft _____ in Weight: _____ lb

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING: (Check only if it applies)

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> abdominal pain | <input type="checkbox"/> common cold | <input type="checkbox"/> hernia | <input type="checkbox"/> prostate enlargement |
| <input type="checkbox"/> acid reflux | <input type="checkbox"/> constipation | <input type="checkbox"/> high blood pressure | <input type="checkbox"/> rheumatoid arthritis |
| <input type="checkbox"/> alcoholism | <input type="checkbox"/> depression | <input type="checkbox"/> hip pain | <input type="checkbox"/> sciatica |
| <input type="checkbox"/> allergies (air born) | <input type="checkbox"/> diabetes | <input type="checkbox"/> hyperthyroidism | <input type="checkbox"/> sclerosis, _____ |
| <input type="checkbox"/> anemia | <input type="checkbox"/> disc disorder, cervical | <input type="checkbox"/> hypoglycemia | <input type="checkbox"/> seizures /convulsions |
| <input type="checkbox"/> arm pain | <input type="checkbox"/> disc disorder, thoracic | <input type="checkbox"/> hypothyroidism | <input type="checkbox"/> shoulder pain |
| <input type="checkbox"/> arthritis | <input type="checkbox"/> disc disorder, lumbar | <input type="checkbox"/> incontinence | <input type="checkbox"/> sleeplessness |
| <input type="checkbox"/> asthma | <input type="checkbox"/> earache/ear infection | <input type="checkbox"/> infertility | <input type="checkbox"/> skin infection |
| <input type="checkbox"/> back pain | <input type="checkbox"/> edema | <input type="checkbox"/> joint pain | <input type="checkbox"/> spondylosis |
| <input type="checkbox"/> back pain, lower | <input type="checkbox"/> elbow pain | <input type="checkbox"/> knee pain | <input type="checkbox"/> stenosis |
| <input type="checkbox"/> bronchitis | <input type="checkbox"/> emphysema | <input type="checkbox"/> leg pain | <input type="checkbox"/> tendonitis |
| <input type="checkbox"/> bursitis | <input type="checkbox"/> endometriosis | <input type="checkbox"/> menstrual irregularity | <input type="checkbox"/> tinnitus |
| <input type="checkbox"/> candidiosis | <input type="checkbox"/> fatigue, chronic | <input type="checkbox"/> menstrual pain | <input type="checkbox"/> TMJ |
| <input type="checkbox"/> carcinoma/cancer | <input type="checkbox"/> fibromyalgia | <input type="checkbox"/> migraines | <input type="checkbox"/> tingling, numbness, _____ |
| <input type="checkbox"/> carpal tunnel syndrome | <input type="checkbox"/> flu | <input type="checkbox"/> neck pain | <input type="checkbox"/> trigeminal neuralgia |
| <input type="checkbox"/> chest pain | <input type="checkbox"/> foot pain | <input type="checkbox"/> neuroma | <input type="checkbox"/> twitch, tremors |
| <input type="checkbox"/> cholesterol, high | <input type="checkbox"/> hand pain | <input type="checkbox"/> osteoarthritis | <input type="checkbox"/> vertigo |
| <input type="checkbox"/> circulation problems | <input type="checkbox"/> headaches | <input type="checkbox"/> osteoporosis | <input type="checkbox"/> others _____ |
| <input type="checkbox"/> colitis / diarrhea | <input type="checkbox"/> hepatitis, | <input type="checkbox"/> pneumonia | |

Currently Medication &/or Herbs: _____

Previous surgeries (& dates): _____

Have you ever been tested positive for AIDS? Yes No HIV? Yes No Hepatitis C? Yes No

WOMEN ONLY: Last menstrual period: _____

Currently pregnant: Yes No If yes, how long? _____ Ever pregnant: Yes No Number of live births: _____

NOTICE TO THE PATIENT

I am seeking treatment at the Acupuncture Center for the following condition: _____

Pursuant to the requirements of title 3, sec. 205.301(a)(1) of TX. OCC code governing the practice of acupuncture.

I, _____, am notifying the acupuncturist(s), Hsiao-Lan Chung, of the following:

Last Visit Date to PCP: _____ Name of PCP: _____ Referred by PCP? Y N

Currently under another physician's care? Yes No If yes, for: _____

I have been evaluated by a physician (MD/DO) or dentist for the condition being treated within 6 months before receiving acupuncture treatment. Initial of Patient _____ Date: _____

(If no initial above, patient must sign below attesting that the Acupuncturist has referred him/her to a physician as pursuant to the requirement of sec. 205.301(b), title 3, TX OCC code governing the practice of acupuncture.) I recognize that I should be evaluated by a physician (MD/DO) or dentist for the condition being treated by the acupuncturist. This serves as a referral by the acupuncturist for me to see a physician. It is my responsibility and choice whether to follow his or her advice.

Patient's signature _____ Date _____

Pursuant to the requirements of title 3, sec. 205.301(a)(2)(c) of TX OCC code governing the practice of acupuncture:

I have received a referral from my CHIROPRACTOR within the last 30 days for acupuncture? Yes No

After being referred by a chiropractor, if after 30 days or 20 treatments, whichever comes first, no substantial improvement occurs in the condition being treated, I understand that the acupuncturist is required to refer me to a physician, and consider this written notice a referral in advance. It is my responsibility and choice whether to follow this advice.

Patient's signature _____ Date _____