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; Wan-Tsu Hsueh, LMT; Nikki Kraemer, LMT; Vanessa Orta-Gonzales, LMT; 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 C & C Wellness Center, Inc (dba Chernly and Chung Acupuncture Center, Inc) and Chung's Family Healthcare Association.

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 /Chernly and Chung Acupuncture Center, Inc, or Hsiao-Lan Chung/C & C Wellness Center, Inc. or Hsiao-Lan Chung/ Chung's Family Healthcare Association 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 /Chernly and Chung Acupuncture Center, Inc, or Hsiao-Lan Chung/C & C Wellness Center, Inc. or Hsiao-Lan Chung/ Chung's Family Healthcare Association

_____

Patient/Guardian name print **Patient/Guardian Signature** **Date**

INSURANCE INFORMATION

Primary Insurance Company:_____ **Member ID # :** _____**Group # :** _____

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

Insured's Birth Date: _____ **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#**_____

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

MEDICAL HISTORY **Patient Name: _____**

Height: _____ ft_____ in Weight: _____ lb Blood Pressure(BP):_____/_____ mmHg

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

_____ abdominal pain	_____ common cold	_____hernia	_____ prostate enlargement
_____ acid reflux	_____ constipation	_____high blood pressure	_____ rheumatoid arthritis
_____ alcoholism	_____ depression	_____hip pain	_____ sciatica
_____ allergies (air born)	_____ diabetes	_____hyperthyroidism	_____ sclerosis, _____
_____ anemia	_____ disc disorder, cervical	_____hypoglycemia	_____ seizures /convulsions
_____ arm pain	_____ disc disorder, thoracic	_____hypothyroidism	_____ shoulder pain
_____ arthritis	_____ disc disorder, lumbar	_____incontinence	_____ sleeplessness
_____ asthma	_____ earache/ear infection	_____infertility	_____ skin infection
_____ back pain	_____ edema	_____joint pain	_____ spondylosis
_____ back pain, lower	_____ elbow pain	_____knee pain	_____ stenosis
_____ bronchitis	_____ emphysema	_____leg pain	_____ tendonitis
_____ bursitis	_____ endometriosis	_____menstrual irregularity	_____ tinnitus
_____ candidiosis	_____ fatigue, chronic	_____menstrual pain	_____ TMJ
_____ carcinoma/cancer	_____ fibromyalgia	_____migraines	_____ tingling, numbness, _____
_____ carpal tunnel syndrome	_____ flu	_____neck pain	_____ trigeminal neuralgia
_____ chest pain	_____ foot pain	_____neuroma	_____ twitch, tremors
_____ cholesterol, high	_____ hand pain	_____osteoarthritis	_____ vertigo
_____ circulation problems	_____ headaches	_____osteoporosis	_____ others_____
_____ colitis / diarrhea	_____ hepatitis,	_____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

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

_____

Patient must sign below attesting that the Acupuncturist has referred him/her to a physician as pursuant to the requirements of title 3, sec. 205.301(a))(1) and 205.301(b) of TX OCC codes governing the practice of acupuncture:

I, _____ ,am notifying the acupuncturist(s), Hsiao-Lan Chung or the clinical staff 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 (DDS/DMD) for the condition being treated within 6 months before receiving acupuncture treatment.

Yes_____ on date of : _____ Initial of Patient_____

No_____ I recognize that I should be evaluated by a physician (MD/DO) or dentist (DDS/DMD) 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.

I have received a referral from my CHIROPRACTOR within the last 30 days for acupuncture?

Yes___ 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 his or her advice.

No_____ I recognize that I should be evaluated by a physician (MD/DO) or dentist (DDS/DMD) 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** _____