Acupuncture and Chinese Medicine Clinic
9301 Linder Way NW, #101, Silverdale, WA 98383
Phone: (360) 692-7000 Fax: (360)698-4699 www.1stwellness.com

(Please Print)

Date _____/_____/_____

Personal Information

Last Name: _____ First Name: _____Middle: _____

Mailing address : _____

City: _____ State: _____ Zip Code: _____

Cell Phone: (_____) _____-_____ Home Phone: (_____) _____-_____

Email: _____ Work Phone: (_____) _____-_____

Date of Birth: _____

Age: _____ Sex: M / F Marital Status: S M W D Sep

Number of Children:_____

Emergency Contact: _____ Phone: (_____) _____-_____

Primary Physician: Dr. _____

Working and Insurance Information

Employed by: _____ Occupation: _____

Insurance Co. _____ Plan/Group: _____

Policy ID#: _____ Co-pay$: _____Deductible$: _____

Relationship to insured: Self Spouse Child Other

Information on insured (If other than yourself)

Name: _____ Date of Birth: _____

Address: _____ Phone Number: _____

Employer: _____

Secondary Insurance: (if covered by more than one) _____

Policy ID#: _____

Whom may we thank for referring

Referred by: _____

Advertisement in: _____

Other: _____

Patient's Name: _____ Date: ____/____/____

Health Related Information

Please list the main problems that you are having, or reasons for this appointment:

_____

_____

_____

Have you seen other health care providers for this? (If yes, please list the diagnosis and treatments)

_____

_____

_____

Medical History

Serious Illnesses:_____

Surgery:_____

Major accidents:_____

Current medications: _____

_____

Current supplements/Herbs:_____

_____

Others:_____

Allergies (Medications, Food and Environment etc):

_____

_____

Habits (Coffee, Tobacco, Alcohol and Drugs etc) or Special diet and exercises:

_____

HIV positive: (yes) ____ (no) ____

Any other problems would you like to discuss:

_____

Patient's Name: _____ Date: ____/____/____

Informed Consent to Acupuncture & Chinese Medicine Treatment

Washington law requires that each patient be informed regarding the scope of practice in which a licensed acupuncturist is allowed to engage. Acupuncture and Chinese Medicine Clinic practice includes: use of disposable acupuncture needles and electric stimulus to stimulate acupuncture points and meridians; acupressure; dermal friction technique; infra-red heat treatment; cupping, Chinese herbs and dietary advice based on Traditional Chinese Medicine.

Side effects may occur in a small percentage of patients and may include the following: some pain following treatment in the treated area, minor bruising or bleeding, infection, burn from heat lamp, needle sickness (fainting),miscarriage, pneumothorax, and broken needle. **If you have a severe bleeding disorder, have a pacemaker, or you are pregnant, please let your provider know prior to treatment**.

Financial Policy

Health and accident insurance policies are arrangements between an insurance carrier and yourself. Your provider will prepare necessary reports and forms to assist you in receiving the coverage by your insurance company for the treatment. Any co-payment required by your insurance company or payment for non-insured patient is expected at the time of the visit.

Confidential Policy

Acupuncture and Chinese Medicine Clinic keeps a record of the health care services that the provider renders to you. We will not disclose your records to others unless you direct us to do so, or the law authorizes, or compels us to do so.

Patient Consent

I read the above information and agree that I am well informed regarding the treatments provided by my provider and had an opportunity to ask questions about them. I also understand that I am responsible to pay all services rendered to me that my insurance carrier does not cover. By signing below, I agree to receive the treatments. I understand that my consent covers the entire course of treatment for my present condition and for any future conditions for which I seek treatment from my provider.

Patient Signature: _____ Date: _____

Parent or guardian Signature: _____