PATIENT INTRODUCTION

Date: ___/_____/_____

FEES PAYABLE WHEN SERVICES ARE RENDERED UNLESS OTHER ARRANGEMENTS ARE MADE
WE ARE REQUIRED BY LAW TO MAINTAIN ORIGINAL RECORDS AS PROPERTY OF THIS CLINIC

PERSONAL INFORMATION

Full Name: ______________________________ Email: ______________________________

Address: ______________________________ City: _______ State: ______ Zip: ____________

Home Phone: ________________ Cell Phone: ______________ Sex: _____ Marital Status: S M D W

Age: ________ Birthday: ____/____/____ Occupation: ______________________________

Employer: ____________ Employer's Phone #: ____________ Have you had acupuncture before? : Yes No

Family Physician (Name & Phone Number): ______________________________

Emergency Contact: ________________ (relation) ____________ Phone #: ________________

Name of person responsible for the account: ________________ Method of Payment: ____________

Would you like to receive updates and specials via email: Yes ____________ No ____________

Who referred you to our clinic? ______________________________

Please list any medications, homeopathics, herbs or supplements that you are taking: ________________

____

PRESENT COMPLAINT

Briefly Describe symptoms: ______________________________

Any Known Allergies: ______________________________

Other Doctors seen for this condition (names and phone numbers): ______________________________

FOR WOMEN ONLY Are you pregnant: ________ Date of last menstrual period: ____/____/____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I, ________________, have requested the release my records which are at (facility name), ______________________________. I hereby request and authorize you, your employees and agents to furnish to the person(s) listed below or anyone designated in writing by them, all copies of records and reports, including copies of x-rays and photostatic copies, abstracts or excerpts of all records and any other information they may request relating to any examination, treatment or opinion concerning any condition that I may have had in the past, now have, or may have in the future.

Patient Signature: ______________________________ Date: ____/____/____

CONSENT FOR TREATMENT OF A MINOR

I herby authorize the practitioners at the Restorative Acupuncture to perform diagnostic tests and to administer treatment as he/she deems necessary to my child, ________________________.

Patient Signature: ______________________________ Date: ____/____/____