FIRST NAME _____ DOB _____ TODAY'S DATE _____

LAST NAME _____ GENDER: ☐ M ☐ F PHONE #1 _____

EMAIL _____ PHONE #2 _____

INSURANCE COMPANY _____ POLICY ID # _____

EMERGENCY CONTACT NAME/ PHONE _____

OCCUPATION _____ # YEARS _____

PLEASE READ AND INITIAL THE FOLLOWING:

_____ ☐ YES ☐ NO Is it alright to leave phone messages containing health related information, such as for filling prescriptions or treatment follow-up?

_____ ☐ YES ☐ NO Is it alright to send emails containing content, such as: promotions, discounts or health related newsletters?

_____ All payments are due at time of service unless arrangements have been made prior to treatment. We accept cash, Visa, Discover, American Express and MasterCard. Debit and credit cards will be charged $2.00 per transaction for amounts less than $50.

_____ We bill insurance for office visits as a courtesy. Your provider may cover some or all of the services we provide. All deductibles, co-pays, and payments for services not covered by your plan are your responsibility.

_____ Any cancellations of office visits made less than 24 hours before an appointment will incur a $45.00 charge. (No cancelations allowed on mobile visits. Reschedule only, with greater than 24hr notice.)

_____ SIGN HERE IF YOU HAVE RECEIVED A COPY OF HIPAA NOTICE OF PRIVACY PRACTICES.

How did you hear about our services? _____

What other health care are you currently receiving? _____

Are you new to acupuncture or herbal medicine? ☐ YES ☐ NO

PRIMARY HEALTH CONCERNS:

1. _____

2. _____

SECONDARY HEALTH CONCERNS:

1. _____

2. _____

PACEMAKER: Do you now have an artificial pacemaker? (a medical device to regulate heart beat)

☐ YES ☐ NO

CHRONIC DISEASES: Do you now have any chronic (or long term) diseases?

☐ YES ☐ NO Please list: _____

CONTAGIOUS DISEASES: Do you now have any contagious (or infectious) diseases?

☐ YES ☐ NO Please list: _____

BLEEDING DISORDERS: Do you now have any kind of bleeding disorder?

☐ YES ☐ NO Please list: _____

ALLERGIES: Are you now allergic or hypersensitive to any foods, drugs, or medications?

☐ YES ☐ NO Please list: _____

FEMALE PATIENTS ONLY: Are you now pregnant, or could you potentially become pregnant?

☐ YES ☐ NO

Signature _____ **Date:** _____