## Patient Information

Date:

### General Information

Patient Name: ______________________________________________ Date of Birth: __________________

Social Security: ________________________________ Driver's License: ________________________________

Patient Sex: ☐ M ☐ F Marital Status: ☐ S ☐ P ☐ M ☐ D ☐ W

Patient Address: Street:__________________________________________________________________

City & Zip: ________________________________________________________________

Home Phone: ________________________ Cell Phone:___________________________

E-mail: _____________________________ Work Phone:_________________________

Emergency Contact: Family Physician: ___________________________ Phone:_________________________

Relative: _________________________________ Phone:_________________________

Referred By: _____________________________________________ Phone:_________________________

### Insurance Information

Insurance Company: _______________________________ Phone:____________________________________

Group/Plan #: ___________________________________ Member #:_________________________________

Subscriber Name: _________________________________ Relation to Patient:_________________________

Subscriber Date of Birth: ___________________________ Subscriber Social Security: ______________________

Subscriber Employer:_____________________________________________________________________

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charges. It is your responsibility to pay any deductible amount co-insurance, or any other balance not paid for by your insurance. You fully understand that you are financially responsible for all charges whether or not paid by your insurance company. You hereby authorize said assignee to release all information necessary to secure payment and further direct your insurance company to pay your Acupuncturist directly for all the services rendered. If this account is assigned for collection or suit, collection costs and/or interests, and/or attorney fees, and/or court costs will be added to the total amount due.

Responsible Party to Patient:____________________________Name if Different:__________________________