Patient Registration

(Please Print and Answer All Questions)

Today's Date _____ Home Phone _____ Cell Phone _____

Text appointment reminders? Y ☐ N ☐

Patient Information

Name: _____ Soc. Sec. #: _____
Last Name First Name Initial

Address: _____

City: _____ State/Province: _____ Zip/Postal Code: _____

Sex: ☐ Male ☐ Female Age: _____ Birth Date:_____ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

☐ Employed Full Time ☐ Employed Part Time ☐ On Disability ☐ Full Time Student ☐ Part Time Student

Patient Employed By: _____ Occupation: _____

Business Address: _____ Business Phone: _____

Primary Physician: _____ Other Physician/Therapist: _____

Whom may we thank for referring you? _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Billing and Insurance

Person Responsible for Bill: _____
Last Name First Name Initial

Relationship to Patient: _____ Birth Date: _____ Soc. Sec. #: _____

Address (if different from patient's): _____

City: _____ State/Province: _____ Zip/Postal Code: _____

Person Responsible Employed By: _____ Occupation: _____

Business Address: _____ Business Phone: _____

Primary Insurance Company: _____

Billing Address: _____ Phone #: _____

Contract/Claim #: _____ Group #: _____ Subscriber #: _____

Is patient covered by additional Insurance? ☐ Yes ☐ No If yes,

Subscriber Name: _____
Last Name First Name Initial

Relationship to Patient: _____ Birth Date: _____ Soc. Sec. #: _____

Secondary Insurance Company: _____

Billing Address: _____ Phone #: _____

Contract/Claim #: _____ Group #: _____ Subscriber #: _____

Assignment and Release

I, the undersigned, certify that I (or my dependent) have insurance coverage with the above insurance company(s) and assign directly to Valley Acupuncture Center all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the acupuncturist or insurance company to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ _____
Signature of Insured/Guardian Date

(over)

Medications/Herbs/Supplements

Please list any medications, herbs or supplements you may be taking or have taken in the last 2 months: _____

_____

_____

_____

Past Medical History

Past Major Illnesses (Cancer, Diabetes, Hepatitis, High Blood Pressure, Heart Disease, Rheumatic Fever, Thyroid Disease, Seizures, Venereal Disease, etc. Please include dates.): _____

_____

Hospitalizations, Surgeries (type of and date): _____

_____

Significant Traumas (auto accidents, falls, etc.): _____

_____

Significant Dental Work (type and date): _____

_____

Birth History (prolonged labor, other difficulties/complications): _____

_____

Allergies (drugs, chemicals, foods, environmental, and their results): _____

_____

Family Medical History

Mother (check): ☐ Diabetes ☐ Cancer ☐ High Blood Pressure ☐ Heart Disease
☐ Stroke ☐ Seizures ☐ Asthma ☐ Allergies ☐ Other: _____

Father (check): ☐ Diabetes ☐ Cancer ☐ High Blood Pressure ☐ Heart Disease
☐ Stroke ☐ Seizures ☐ Asthma ☐ Allergies ☐ Other: _____

Siblings (check): ☐ Diabetes ☐ Cancer ☐ High Blood Pressure ☐ Heart Disease
☐ Stroke ☐ Seizures ☐ Asthma ☐ Allergies ☐ Other: _____

Other Family Members _____ (check): ☐ Diabetes ☐ Cancer ☐ High Blood Pressure
☐ Heart Disease ☐ Stroke ☐ Seizures ☐ Asthma ☐ Allergies ☐ Other: _____

Patient Screening

Have you traveled outside the United States or Canada in the past year? ☐ Yes ☐ No

If so, when and where: _____

Have you had acupuncture before?	☐ Yes ☐ No	Do you have Hepatitis or AIDS?	☐ Yes ☐ No
Are you nervous about needles?	☐ Yes ☐ No	Have you ever had Hepatitis?	☐ Yes ☐ No
Do you have a tendency to faint?	☐ Yes ☐ No	Do you bleed for a long time?	☐ Yes ☐ No
Are you very hungry right now?	☐ Yes ☐ No	Do you bruise easily?	☐ Yes ☐ No
Are you very tired right now?	☐ Yes ☐ No	Do you wear a pacemaker or insulin pump?	☐ Yes ☐ No
Women - are you pregnant?	☐ Yes ☐ No	Are you sensitive to metals on your skin?	☐ Yes ☐ No

Tobacco: ☐ Never ☐ <1/2 pack/day ☐ 1/2-1 pack/day ☐ 1-2 packs/day ☐ >2 packs/day ☐ Quit when: _____

Alcohol: ☐ Never ☐ Rarely ☐ 1-3x/month ☐ 1-2x/week ☐ 3-6x/week ☐ Daily ☐ Quit when: _____

Caffeine (coffee, tea, cola, etc.): ☐ Never ☐ Occasionally ☐ 1-2 cups/day ☐ 3-4 cups/day ☐ >4 cups/day

Other Non-Medicinal Drugs: _____

How often: ☐ Never ☐ Rarely ☐ 1-3x/month ☐ 1-2x/week ☐ 3-6x/week ☐ Daily ☐ Quit when: _____

Do you have a seizure disorder? ☐ Yes ☐ No Are you undergoing any other therapies now? ☐ Yes ☐ No

If so, please describe: _____