Mind & Body
ACUPUNCTURE

PATIENT INFORMATION

Last Name: _____ First Name:_____

Today's Date: _____/_____/_____ Age:_____ O Female O Male

Date Of Birth: _____/_____/_____ Marital Status: S M D W

Address: _____ Apt. #: _____

City: _____ State: _____ Zip: _____

Home Phone ( ) _____ Cell ( ) _____

E-mail: _____

Employer: _____ Occupation: _____

*Would you like to receive newsletters or promotional information in the future? Yes No

EMERGENCY CONTACT

Name: _____ Relationship: _____

Daytime Phone ( ) _____ Evening ( ) _____ Cell ( ) _____

◆IF PATIENT IS UNDER 18 YEARS OF AGE◆

Guardian Name: _____ Relationship: _____

Phone ( ) _____ Billing Address: _____

RELEASE OF INFORMATION

The Provider is authorized to furnish from the patient's record, necessary information to the referring physician, if any, and to others to the extent required in connection with a claim for aid, insurance, or medical assistance to which the patient may be entitled. The patient or patient's representative hereby authorizes the provider to obtain her/his medical records from previous medical history rendered by other physicians or medical centers.

X_____ X_____

Signature of Patient Date Signature of Representative Date