Patient Information Questionnaire

Name:_____Today's date:_____
Address:_____
City:_____Zip:_____
Home Telephone:_____Work Telephone:_____
Patient Status: Married□ Domestic Partnership□ Single□ Divorced□ Widowed□
Birth Date:_____Age:_____Gender:_____Social Security #:_____
Email:_____
Referred to our clinic by:_____
Emergency Contact:_____Relationship:_____
Emergency Contact Telephone:_____

Employment Status: Full-time□ Part-time□ Retired□ Unemployed□ Student□
Occupation:_____
Employer's Name:_____
Employer's Address:_____Telephone:_____
Spouse's Name:_____
Spouse's Employer:_____
Spouse's Employer's Address:_____Telephone:_____
Physician's Name:_____Telephone:_____
OB/GYN's Name:_____Telephone:_____
Date of late physician or OB/GYN visits:_____

Insurance Information
Primary Insurance:_____Telephone:_____
Policy Holder's Name:_____Relationship:_____
Policy or Member ID:_____Group:_____

Insurance Responsibility Statement:
Having insurance is not a substitute for payment. Many companies have fixed allowances or percentages based on your contract with them, not with our clinic. It is your responsibility to pay the deductible, co-payment, and any other balances not paid by your insurance. We will assist you in billing your insurance company as much as possible. However, you are responsible for your bill.

Assignment and Release:
I hereby assign my insurance benefits to be paid directly to the provider of service. I understand that I am financially responsible for any non-covered services. I also authorize the provider to release any information required to process any claims.

Cancellation Policy:
There is a 24-hour cancellation policy for acupuncture appointments. Late cancellations and missed appointments will be billed at $85.

Signed:_____**Date:**_____