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:**__________