

Healing Response Acupuncture & Integrative Medicine

New Patient Information

Name: _____ Date: _____
Address: _____ City: _____ State: _____ Zip: _____
Tel#: Home _____ Work: _____ Best Time/Place to call? _____
Birth date: _____ Sex: Male Female **Social Security #** _____
Your Dr.'s Name? _____
Student: Y N Full Part-time Marital Status (please circle one) M S W D
Occupation: _____ Employer: _____
Spouse or Parent's: Name _____ **Social Security #** _____
Birth Date: _____ Employer: _____
Person responsible for payment on this account: _____

Insurance Information

Are you covered by Medicare? Yes No Please be advised that this office is ***NOT*** contracted with Medicare/Medicaid.

Do you have any group, union or personal health and accident insurance? Yes No

Name of Insured: _____ Relation to patient: _____

Insurance Co.: _____ Policy# _____

Group # _____ ID # _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____

Additional Insurance Company (if any): _____ Group # _____

Name of Insured: _____ Relation to patient: _____ Policy # _____

Address: _____ City: _____ State: _____ Zip: _____

Please complete the following important information.

Is your condition due to an accident? Yes No **If no, then what was the Date of onset?** _____

If yes please complete the following : Date of Accident: _____ **State** _____

Were you involved in an / automobile accident / work related accident / other (Please circle one)

Were you recently hospitalized? Yes No If yes, **When?** _____

Who may I thank for referring you to my office? _____

Have you had or are you currently having other acupuncture? Yes No If yes, where and when? _____

Read Carefully and Sign Below

I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I agree to allow Healing Response Acupuncture & Integrative Medicine to bill my insurance company as a courtesy, permit the release of records necessary to process my claims, and authorize payments to be made directly to Healing Response Acupuncture & Integrative Medicine for treatment rendered. I further understand that co-payments are due at time of service and that I may be billed for charges not covered by my insurance company.

Patient's Signature: _____ Date: _____

Parent or Guarantor's Signature: _____ Date: _____