EnPointe Acupuncture

PATIENT INFORMATION

Patient Name_____ _ Date _____

PATIENT INFORMATION

Name_____

Home
Address_____

_____
City State Zip

Sex: ☐M ☐F Age_____ Birthdate_____

☐Single ☐Married ☐Significant Other

☐Widowed ☐Separated ☐Divorced

Occupation_____

Employer_____

Emp.
Address_____

Spouse/Partner's
Name_____

Occupation_____

Spouse/Partner's
Employer_____

Whom may we thank for referring you? How did you find us?

_____

_____

GENERAL INFORMATION

Have you had acupuncture before? ☐Yes ☐No

Have you used Chinese herbal medicine? ☐Yes ☐No

Are you currently under the care of a physician?

Physician's name:_____

Physician's phone:_____

Are you, or could you be currently pregnant?
☐Yes ☐No Due date_____

Do you have any bleeding disorders? ☐Yes ☐No

BILLING INFORMATION

Who is responsible for this
account?_____

Relationship to Patient_____

Is a Superbill needed for Insurance reimbursement?
☐ Yes ☐No

Is a receipt needed for FSA reimbursement?
☐ Yes ☐No

Is a receipt needed for your records?
☐ Yes ☐No

RELEASE

I understand that I am financially responsible for all charges whether or not paid by insurance. I understand that all charges are due the day of service.

_____ _____
Responsible Party Signature Date

CONTACT INFORMATION

I give permission to EnPointe Acupuncture to contact me by:

☐ Home phone ☐ Work phone ☐ Cell phone

☐ Text message ☐ Email

Home Phone_____

Work Phone_____

Cell Phone_____

Email Address: _____

EMERGENCY CONTACT

Name_____
Relationship_____
Home phone_____
Work phone_____
Cell Phone _____

Patient Signature: _____ Date: _____