Arcadia Acupuncture Clinic

Patient Information

Name _____

Address _____ City, State, Zip _____

Mailing Address _____ City, State, Zip _____

Home Phone _____ Cell Phone _____

Business Phone _____ Email _____

How may we contact you? ☐ Home ☐ Cell ☐ Work ☐ Email

Date of Birth _____ Gender ☐ Female ☐ Male

Social Security No _____ Marital Status ☐ Single ☐ Married ☐ Other

Emergency Contact _____ Phone Number _____

Referred by _____

Medical Insurance Information

Insured Name _____

Insured Date of Birth _____

Relationship to Insured ☐ self ☐ spouse ☐ child ☐ other

Insured ID Number _____

Insured Policy Group Number _____

Insurance Plan/Program Name _____

Claims Address _____

I have read the above information and certify it to be true and correct to the best of my knowledge and belief and hereby authorize this office to do whatever is necessary, in accordance with state statutes, for the care and management of this complaint.

Date _____

Patient Signature (guardian if minor) _____