Patient Information Sheet

KELLY HER ACUPUNCTURE

970 S. Petit Ave., #D Ventura, CA. 93004 | Phone: (805) 302-0266 | Fax: (805)659-4767

Confidential

Last Name:	First Name:	Preferred Name:	Occupation:	Referred By:
Gender M☐ F☐	Date of Birth:	Age:	Marital Status: Single☐ Married☐ Divorced☐	Tel:
Address:		City:	State:	Zip:
Home Phone:		Work Phone:	Cell Phone:	
Emergency Contact & Relationship:		Phone Numbers of Emergency Contact: Primary:	Alternate:	
Check Health Insurance Coverage: None☐ PPO☐ POS☐ HMO☐ Work's Comp☐ Auto Injury with Med Pay☐				
Email Address: Please be assured that your e-mail address will only be used by our office for your needs and will not be sold to another company or individual.				
Primary Care Doctor: Name:	Tel:	Specialty:		
Other Doctor You See: Name:	Tel:	Specialty:		
Major Complaints:				

	Yes	No		Yes	No
Do you have a tendency to faint?	☐	☐	Are you HIV+?	☐	☐
Do you have a pacemaker?	☐	☐	Are you pregnant? (women)	☐	☐
Do you bleed for a long time?	☐	☐	Have you ever had Hepatitis?	☐	☐

Medication: Please list all prescription medications you use. Include those which you may only use occasionally:

Prescription Name	Purpose:	How Long	Dose	How Often	Last Dose

1. For most cases we do not bill insurance directly. Patients are expected to take care of their fees as services are rendered.
2. We do not accept responsibility for collecting your insurance claim or for negotiating a settlement of a disputed claim. However, we will gladly prepare a doctor's statement of charges for you to submit to your insurance carrier for reimbursement.
3. If you need to cancel an appointment, please inform us at least 24 hours in advance.
4. There is a service charge of $25 for every returned check.
5. I authorize the release of any medical records and/or any other necessary information to process a claim with my insurance.
6. Kelly Her Acupuncture is in compliance with HIPPA law and regulations.

I have read and agree to the terms of the preceding paragraphs. All information presented is true to the best of my knowledge.

Patient's Signature _____ Date _____