

## Patient Information Questionnaire

Name: \_\_\_\_\_ Today's date: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home Telephone #: \_\_\_\_\_ Work Telephone #: \_\_\_\_\_  
Patient Status: Married  Domestic Partnership  Single  Divorced  Widowed  Other \_\_\_\_\_  
Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Social Security #: \_\_\_\_\_  
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 Employers Address: \_\_\_\_\_ Telephone #: \_\_\_\_\_  
Physician's Address: \_\_\_\_\_ Date of last visit: \_\_\_\_\_  
Date of injury of onset of illness: \_\_\_\_\_



### INSURANCE INFORMATION

Primary Insurance: \_\_\_\_\_ Telephone #: \_\_\_\_\_  
Insurance billing information: \_\_\_\_\_  
Policy Holder's Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Policy # / ID #: \_\_\_\_\_ Group #: \_\_\_\_\_  
Secondary Insurance: \_\_\_\_\_ Telephone #: \_\_\_\_\_  
Insurance billing information: \_\_\_\_\_  
Policy Holder's Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Policy # / 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 same day cancellation policy for acupuncture appointments. A missed appointment will be billed at \$25.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_