Wendy Stedeford Acupuncture
Patient Information Form

Please fill out Both the Front and Back

First name: ______________________ Last: ________________ MI: _____ Today's Date: ___________

Date of Birth: ___________________________ Social Security number if necessary: ____________

Address: ____ Apt. # ____________

City: ___________________________________ State: ______________ Zip code: __ __________

Occupation: ____

Employer/School: ____

Please give us the best phone number where we can leave messages with information regarding your appointments and/or treatments: _____________________________ home/cell/work

Other numbers where we can reach you: _________ ___________________ home/cell/work
____ ___________________ home/cell/work

If you are interested in our enewsletter please give us your email address: ______________________

How did you hear about us? (Please circle)

Newspaper ad or story   Phone book   Mailer/flyer   Website   Event   Medical referral
Friend/Family   Other: ____

Emergency Contact Info:

Name and relationship to patient: ____

Phone number and alternative way to reach the emergency contact: ___________________________

Type of Patient

Please Circle: Are you a: CASH INSURANCE WORK COMP PERSONAL INJURY patient?

Date of onset of chief concern or injury: ____

If you are a **CASH** patient, please skip to the next shaded section
If you are an **INSURANCE, WORK COMP** or **PERSONAL INJURY**, please fill out the relevant information below. Thank you

Insurance
Insurance company name: ____
Are you the insured? Yes No
If not, What is the name of the insured? ________________________________
Their date of birth: ______________________

(Insurance information continued)

ID #: ___________________________________

Subscriber #: ___________________________

Work Comp

Employer's name and phone #: ____

Date of injury: ____________________________________

Claim #: ____

Insurance carrier name: ____

Their address:____

Phone #: ____

Your Adjuster's name: ____

Their phone and fax #'s: ____

Auto Insurance/Personal Injury

Date of injury: ____

Claim #: ____

Insurance carrier name: ____

Their address: ____

Their phone and fax #'s: ____

Your Adjuster's name and #: ____

Your Attorney's name and #: ____

Health Information

Present Health Concerns

Please list the most important health concerns in their order of significance

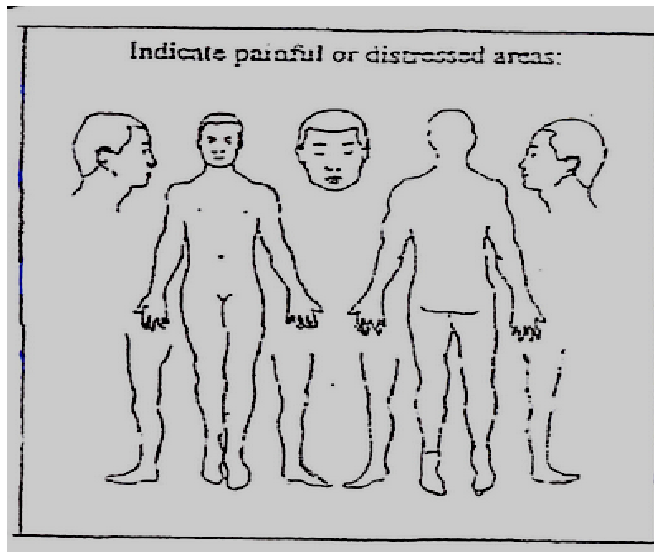
1

2

3

4

Please indicate painful or distressed areas:



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What goals do you have for your visit today?____

____

Have you ever consulted a Naturopathic physician, acupuncturist, nutritionist or counselor before? (Please circle)

Do you have any questions about the care that you've chosen today? Please be sure to ask during treatment!

Please list prescription medications you are currently taking and the dosages:

1____

2____

3____

4____

5____

Please list any vitamins, minerals, herbs or homeopathic remedies you are currently taking and their dosages:

1____

2____

3____

4____

5____

Please list any severe or life-threatening allergies: (Please explain)_____________________________

____

Personal Habits

Please circle any of the following substances that you regularly use:
tobacco alcohol coffee black tea cola

Do you follow any particular diet regimens or restrictions? If yes, please describe:_______________

____

Do you exercise regularly? If yes, what type and how often? ___________________________________

____

Past History

Hosptalizations: ____

Serious illnesses and/or injuries: ____

Date of last physical/annual exam:_____________________________Most recent blood test:________

Personal and Family Histories

Please circle if you or a family member have ever experienced these conditions

alcohol or drug addiction	self	family member
allergies	self	family member
anemia	self	family member
arthritis	self	family member
asthma	self	family member
cancer	self	family member
depression	self	family member
diabetes	self	family member
eczema	self	family member
epilepsy	self	family member
headaches	self	family member
heart disease	self	family member
hepatitis	self	family member
high blood pressure	self	family member
kidney disease	self	family member
mental illness	self	family member
stroke	self	family member
tuberculosis	self	family member
Other_________________________	self	family member

Rules and Regulations Section PLEASE READ CAREFULLY!

LATE AND NO SHOW POLICY

Life can get crazy these days for everyone. When you come for treatment, you should be able to unwind and let your treatment ***really*** work for you. If life suddenly throws you a curve ball and you need to cancel or reschedule that's understandable. Please arrange it at least 24 hours ***prior*** to your appointment. Just in case it's a chronic problem or a non-emergency, we reserve the right to charge a no-show fee. The first no-show is a $30.00 fine and any others following will be the cost of a full visit. We'll do our best to respect your timing issues and we'll be happy if you do the same for us.

RESPONSIBILITY FOR PAYMENT

As a courtesy to you, and if it is pertinent to your situation, we will gladly submit your charges to the appropriate parties. H However, all services rendered by this office are charged directly to you. Ultimately, you are personally responsible for payment of these charges regardless of any insurance reimbursement or settlement you may or may not receive.
Returned checks will result in a $40.00 charge.

IMPORTANT PLEASE READ

We always strive for excellence when it comes to patients' needs including being aware that your time, as well as ours, is precious. Please make every effort to arrive on time and we will make every effort to make sure you are seen promptly. If for some reason your appointment is pushed back, please understand that it could be because another patient is in dire need. And if that isn't the reason, then we apologize beforehand!

Also, please understand that every individual is unique in their anatomy. Occasionally, because acupuncture does use needles, you ***may*** experience ***slight*** bruising. This is a temporary result and will not adversely affect the benefits you receive from your treatment. If a needle causes you discomfort while it is being inserted, let your practitioner know and they can adjust the needle for you.

It's also very important to have eaten something within 4 hours of treatment or to let your practitioner know if you have any fainting tendencies because of the ***very rare*** chance of needle shock.

Private Policy Notice Acknowledgement of Receipt

I acknowledge that I have received a copy of Wendy Stedeford Acupuncture's
Notice of Privacy Practices and I understand it contains information about the use and disclosure of my medical information.

By way of my signature, I provide Wendy Stedeford Acupuncture with my authorization and consent to use and disclose my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice.

***** It is the practice of this office to have patients wait in a common waiting room before being called by first name back to the treatment room. This office also reserves the right to use a sign in sheet which will be in plain view at the front desk.

Please sign below to acknowledge that you understand and agree to the slight risk involved in receiving treatment with acupuncture needles, that you understand, agree and have received a copy of the Private Policy Notice and that you understand and agree to our late and no show policy **Welcome to the practice! If you have any questions today or at any time we will be happy to answer them and look forward to an enriching exchange with you!**

Signature: ____ Date: ___________________________