Academy for
Five Element Acupuncture

NEW PATIENT INFORMATION				
(Please print)				
Today's date	Birth date	Age	Gender	❑ M ❑ F ❑ _____

Last name	First	Middle	Preferred name

Street address	Cell phone ( )
	Work phone ( )
City	Home phone ( )
State / Zip	Email
Occupation	*Which is your preferred contact and place where we may leave you a message?* ❑ Home phone ❑ Work phone ❑ Cell phone ❑ Email
Other family members seen here	*May we send you updates on our activities via mail/email?* ❑ Yes ❑ No
Referred to clinic by or chose clinic because of *(please check one box)* ❑ Student ❑ Practitioner ❑ Friend ❑ Family ❑ Advertising ❑ Close to home/work ❑ Other	*Who may we thank for referring you to our clinic?*

INSURANCE INFORMATION		
Are you covered by insurance? ❑ Yes ❑ No	Name of insurance (payer)	Plan Name

Insured's name (if not you)	Insured ID #
Group #	Policy #
Patient's relationship to subscriber ❑ Self ❑ Spouse ❑ Child ❑ Other	Send reimbursements to address different from above? ❑ Yes ❑ No **Please list address on back of form*
Claim # if Accident	Date of Accident /Injury

IN CASE OF EMERGENCY		
Name of local friend or relative (not living at same address)	Relationship to you	
Cell phone ( )	Work phone ( )	Home phone ( )

INFORMATION RELEASE

I voluntarily permit my intern practitioner to submit my treatment sheets to Academy personnel for purposes of recordkeeping and academic instruction. I understand that a coding system is used so that my full name is not included on forms used for academic instruction. I have been informed that I may stop treatment at any time.

_____ _____

Patient/Guardian Signature Date signed

Intern Name	

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INSURANCE VERIFICATION

DATE _____

Patient Name	Last Name	First Name	
Patient Address:			
City, State & Zip (MUST HAVE)			
Patient Phone #			
Patient Date of Birth:		Male _____	Female _____
Patient, Subscriber # / ID #			
Group #			
Insured Name & ID# (if different from patient)			
Relationship to Insured	Self ____	Spouse ____	Child ____ Other _____
Insurance Co Name			
Ins. Co. Phone #			
Claim # if an accident:			
Date of Accident/ Injury			
Other Info			
Dx Codes			

To be completed by office staff				**Date Verified**	
Effective Date				Spoke To	
Deductible $				Amount met $	
Acupuncture	Yes /	No	# of Visits _____	% allowed	
Office Visit	Yes /	No			
PT	Yes/	No	# of Visits _____	% allowed	

Insurance Company Address				
Dx Codes	Dx/Code _____		Dx/Code _____	