Academy for
Five Element Acupuncture

RESET

PATIENT INFORMATION

Last name *	First	Middle Initial	Preferred name

Today's date	DOB	Legal Gender: (check one/see note bottom page)*	Pronouns:
		☐ M ☐ F	

Street Address	City	State	Zip

Cell phone	Home phone	Work phone	Best # to reach you	Voicemail message OK?
			☐ Cell ☐ Home ☐ Work	☐ Cell ☐ Home ☐ Work

Email	May we send you updates on our activities via email/mail?	
	☐ Yes	☐ No

Occupation	Who may we thank for referring you?

EMERGENCY CONTACT

Name of relative or friend to contact in an emergency	Relationship to you

Cell phone	Home phone	Work phone

INSURANCE INFORMATION

Insurance Company Name	Insurance phone number

Policy ID / ID #

Insured's name (if not you)	Relationship to Insured	Insured's DOB (if not you)

Claim # if Accident/Injury	Date of Accident/Injury

**While the Academy recognizes a variety of genders/sexes, many insurance companies and legal entities do not. The name/gender you have listed must be the name used on documents pertaining to insurance billing and correspondence. If your preferred name and pronouns are different from these, please let us know.*

Patient/Guardian Signature	Date signed