## Chia Chia Cheng, L.Ac. - Patient Registration

Address       Employer         City/State/Zip       Employer address         Cell phone       City/State/Zip         Other phone       Phone         Email       Emergency contact         Date of birth       Age       Phone         Married       Divorced       Widowed       Relationship	Patient name	Occupation	
City/State/Zip Employer address Cell phone City/State/Zip Dther phone Phone Email Age Phone Date of birth Age Phone Married Divorced Widowed Relationship Subscribe to our newsletter? Yes No Referred by Why are you here? If you've had previous treatment for this condition, describe what worked Dther conditions you would like help with ( <i>in order of importance</i> ) Current medications/drugs Current supplements For offen do you use the following? Tobacco Marijuana Coffee Alcohol Sugeries/Procedures ( <i>with year</i> ) Surgeries/Procedures ( <i>with location</i> ) Past injuries Children ( <i>age, sev, conditions</i> )		Employer Employer address City/State/Zip	
Cell phone City/State/Zip   Other phone Phone   Email Emergency contact   Date of birth Age   Phone Phone   Married Single Divorced Widowed Relationship Subscribe to our newsletter? Yes No Referred by Why are you here? If you've had previous treatment for this condition, describe what worked Other conditions you would like help with ( <i>in order of importance</i> ) Current medications/drugs Current supplements Gurrent supplements Surgeries/Procedures (with year) Surgeries/Procedures (with year) Past injuries Children (age, sex, conditions) Current (age, sex, conditions)			
Other phone Phone   Email Age   Date of birth Age   Phone Phone   Married Divorced   Widowed Relationship   Subscribe to our newsletter? Yes   Wy are you here? Widowed   If you've had previous treatment for this condition, describe what worked Image: Conditions you would like help with (in order of importance)   Current medications/drugs Current supplements   Gurrent supplements Coffee   Altohol Surgeries/Procedures (with year)   Surgeries/Procedures (with location) Past injuries   Children (age, sex, conditions) Image: Conditions			
Email Emergency contact   Date of birth Age   Phone Phone   Subscribe to our newsletter? Yes   Yes No   Referred by			
Date of birth Age Phone	Email		
Married Single   Divorced Widowed   Relationship   Subscribe to our newsletter?   Yes No   Referred by   Why are you here?			
Why are you here?         If you've had previous treatment for this condition, describe what worked         Other conditions you would like help with (in order of importance)         Current medications/drugs         Current supplements         Current supplements         Main in the following?         Tobacco         Marijuana         Coffee         Alcohol         Surgeries/Procedures (with year)         Scars/Tattoos (with location)         Past injuries         Children (age, sex, conditions)	□Married □Single □Divorced □Widowed		
If you've had previous treatment for this condition, describe what worked	Subscribe to our newsletter? □Yes □No	Referred by	
Other conditions you would like help with (in order of importance)         Current medications/drugs         Current supplements         How often do you use the following? TobaccoMarijuanaCoffeeAlcohol         Major illnesses/accidents (with year)         Surgeries/Procedures (with year)         Past injuries         Children (age, sex, conditions)	Why are you here?		
Current medications/drugs	If you've had previous treatment for this condition, describ	e what worked	
Current medications/drugs	Other conditions you would like help with <i>(in order of imported</i> )	nce)	
Current supplements Alcohol		nice/	
How often do you use the following? TobaccoMarijuanaCoffeeAlcohol   Major illnesses/accidents (with year)   Surgeries/Procedures (with year)   Scars/Tattoos (with location)   Past injuries   Children (age, sex, conditions)	Current medications/drugs		
Major illnesses/accidents (with year)	Current supplements		
Major illnesses/accidents (with year)			
Surgeries/Procedures (with year)	How often do you use the following? Tobacco	_Marijuana Coffee	Alcohol
Scars/Tattoos (with location) Past injuries Children (age, sex, conditions)	Major illnesses/accidents (with year)		
Past injuries Children (age, sex, conditions)	Surgeries/Procedures (with year)		
Past injuries Children (age, sex, conditions)	Scare/Tattooc (with leasting)		
Children (age, sex, conditions)			
	Past injuries		
Family history	Children (age, sex, conditions)		
, , <u>,</u>	Family history		

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**Nutritional Response Testing (NRT)** is an optional technique available to you as a patient. NRT is a technique used for finding imbalances in your body's nervous system. NRT is not a diagnostic tool. If you choose to participate in NRT you are aware that the findings are for the purpose of selecting the nutritional and herbal support that is best for your body and that NRT does not produce any working diagnosis.

Do you have insurance which may cover acupuncture?	□No If	fyes, please present insurance card.
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**Insurance Patients:** I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I authorize the release of any medical information necessary to process this claim and authorize payment of services to this office. I understand that any amount paid directly to this office will be credited to my account. I permit this office to endorse co-issued remittance for the conveyance of credit to my account. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment.

If we cannot bill on your behalf, we will provide a superbill to help you submit a claim.

\*\* Insurance benefits quoted are not a guarantee of benefits. It is your responsibility to verify your insurance benefits. We assume no responsibility for information provided to us by either you or your insurance company. Please call your insurance company with specific questions to clarify coverage for acupuncture. Please make payment for your portion of charges at the time of each visit.

**Patients without Insurance**: Please make payment for services at the time of each visit. We accept checks, cash and Visa/Mastercard.

A day of service rate is available to all patients who pay in full at the time of service and for whom we do not need to bill insurance. Patients may opt to pay in full, receive the discount and send their itemized receipt to their insurance company for direct reimbursement.

Patient's signature	_ Date
In case of minor, authorization for treatment by parent or guardian	
Parent or guardian signature	_ Date