

NEW PATIENT REGISTRATION FORM

To help us provide you with the best possible care, please fill out this form **as accurately as possible**. All personal information will be kept **confidential** in your patient file.

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Full Name: _____	Birth Date: / /							
PERSONAL INFORMATION								
Gender: M / F								
Social Security # _____ - _____ - _____	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Other							
Street Address _____								
City _____	State _____ Zip _____							
Phone (Home) (_____) _____ - _____	Phone (Work) (_____) _____ - _____							
E-mail _____	Phone (Cell) (_____) _____ - _____							
Employer _____	Occupation _____							
EMERGENCY CONTACT								
In case of emergency, whom should we contact? Name _____								
Relationship _____	Phone (_____) _____ - _____							
OTHER HEALTHCARE PROVIDERS								
Primary Physician _____	Phone (_____) _____ - _____							
Other healthcare practitioner you see regularly:								
Name _____	Type of Practitioner _____							
REFERRAL INFORMATION								
How did you hear about John Golden Acupuncture? _____								
MEDICAL HISTORY								
Please check the boxes below that are now or have been a part of your personal health history.								
Current	Past	Current	Past	Current	Past			
Addiction	<input type="checkbox"/>	<input type="checkbox"/>	Digestive Disorders	<input type="checkbox"/>	<input type="checkbox"/>	Insomnia	<input type="checkbox"/>	<input type="checkbox"/>
Specify: _____			Emotional Disorders	<input type="checkbox"/>	<input type="checkbox"/>	Irregular Pregnancy	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Menstrual Irregularity	<input type="checkbox"/>	<input type="checkbox"/>
Abortion	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	STD	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Headaches/Migraines	<input type="checkbox"/>	<input type="checkbox"/>	Skin Problems	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Blood Pressure - High	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Ulcer	<input type="checkbox"/>	<input type="checkbox"/>
Blood Pressure - Low	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Urinary Tract Infection	<input type="checkbox"/>	<input type="checkbox"/>
Blood Transfusion	<input type="checkbox"/>	<input type="checkbox"/>	Type: A ____ B ____ C ____			Vaginal Infection	<input type="checkbox"/>	<input type="checkbox"/>
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	Heavy Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Other	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	Specify: _____		
Chronic Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	HIV+	<input type="checkbox"/>	<input type="checkbox"/>	Other	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Hypoglycemia	<input type="checkbox"/>	<input type="checkbox"/>	Specify: _____		
CHIEF COMPLAINT - Please briefly describe your major wellness concern:								

Please list any **MAJOR ACCIDENTS, SURGERIES, OR HOSPITALIZATIONS:**

Incident:

Date:

_____	_____
_____	_____
_____	_____

ALLERGIES – Please list ANY allergic reactions you have had (medications, foods, plants, animals, etc.)

Substance:

Reaction:

Substance:

Reaction:

_____	_____	_____	_____
_____	_____	_____	_____

FAMILY HISTORY – Check any conditions that have been present in blood relatives:

Cancer Stroke Diabetes Heart Problems High Blood Pressure Other: _____

LIFESTYLE FACTORS – Which of the following are a part of your lifestyle?

Tobacco Coffee Alcohol Recreational Drugs Exercise Special Diet: _____

MEDICATIONS & SUPPLEMENTS – Please list all medications, herbs, and nutritional supplements you take.

Substance:

Dosage:

Substance:

Dosage:

Substance:

Dosage:

_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

OFFICE POLICIES:

All fees for goods and services are due at the time of visit unless prior arrangements have been made in writing. Acceptable forms of payment are cash, check, and credit card. To minimize administrative costs we do not file insurance paperwork, but upon request will provide you with a Superbill which you can submit to your insurance company.

If you need to cancel an appointment, please give a minimum of 24 hours notice. There may be a cancellation fee of an amount up to the full cost of the missed treatment session for less than 24-hour notification.

Please Initial Here: _____

✓ I certify that, to the best of my knowledge, the information I have provided herein is accurate and correct.

✓ My signature authorizes the Practitioner named on this form to treat me (or the patient for whom I am legally responsible) with acupuncture, Chinese medicinal herbs, and massage within the licensure granted by the Medical Quality Assurance Board of the State of California and the California Acupuncture Committee.

✓ I authorize the release of any medical or other information necessary for insurance claim processing and I understand that my individually identifiable medical information will be used only as necessary for purposes of treatment, payment, and other healthcare operations.

✓ I have received a copy of the office Notice of Privacy Policies.

Signature _____ Date _____
(Patient, Parent, or Guardian)

FOR OFFICE USE ONLY:

Witness to Patient's Signature _____ Date _____
(Staff or Acupuncturist)