PATIENT REGISTRATION AND MEDICAL HISTORY

Name: Last	First		Date:	
Address:	City:	State:	Zip:	
Phone: [home]	[cell]	Email:		
Preferred contact phone for appointment messages:				
Birth Date:	Age:	Birth Place:	Height	Weight
Status: Single	In relationship	Married		
Spouse Name: Last	First		Spouse Birthdate:	
No. of children	Employer:		Occupation:	
How did you find out about us?		Referred By:		
Emergency contact:	Contact telephone #		Relationship to you	

HAVE YOU EVER HAD ACUPUNCTURE? ☐ Yes ☐ No For what reason?_____

MAJOR SURGERIES, HOSPITIAZATIONS, X-RAYS, MRI'S…

(If you have ever been hospitalized for any serious medical illness, procedures or surgical operations)

Date	Operation, Procedure or Illness	Name of Hospital

LIST ALL MEDICATION YOU ARE CURRENTLY TAKING

Medication	**For what condition**	**Dosage**

FEMALES ONLY:

Pregnant? ☐ Yes ☐ No **Menses:** Length of Cycle_____Days

Flow: Light Heavy Normal **Duration**:_____Days

PERSONAL HABITS

☐ Smoking ☐ Alcohol Vegetarian

PLEASE LIST YOUR TOP 3 HEALTH CONCERNS THAT HAVE BROUGHT YOU HERE IN ORDER OF IMPORTANCE
What would you like to be treated for? (Describe briefly. How long have you had it for? How does it affect you? What treatments have you had before and what was the result?
1.
2.
3.

Do you have silver fillings in your teeth?	☐ Yes	☐ No	Approx. how many teeth are affected ?	
Are you interested in the following?				
☐ Healing for past traumas and memories				
☐ Meditation / Breathing excercise				

Cancellation Policy: There is a $45 fee for any cancellations, no shows and rescheduled appointments without a 24-hour notice.

Signature: _____ Date: _____

SYMPTOMS	NOTE: For each symptom you currently (leave blank if they do not apply)	

LIVER / GALLBLADDER

☐ Irritability	☐ Gall Stones	☐ Poor Circulation
☐ Anger	☐ Dizziness	☐ Soft / Brittle Nails
☐ Depression	☐ Blurred Vision	☐ Emotional Eater
☐ Stress	☐ Feeling of Lump in Throat	☐ Bad Taste in Mouth
☐ Headaches / Migraines	☐ Clenching of Teeth at Night	☐ Bad Breath
☐ Visual Problems	☐ Muscle Cramping / Twitching	☐ Do you Crave: Sour
☐ Red / Dry / Itchy Eyes	☐ Tension	

KIDNEY/ URINARY BLADDER

☐ Urinary Problems Bladder	☐ Decrease Bone Density	☐ Hearing Problems
☐ Infection Dropped Bladder	☐ Feel Cold Easily	☐ Cavities
☐ Incontinence	☐ Cold Hands	☐ Fear
☐ Lack of Bladder Control	☐ Excess Sexual Desire	☐ Hot Flash/ Night Sweating
☐ Weakness	☐ Poor Memory	☐ Do you crave: Salty
☐ Pain in Lower Back	☐ Loss of Hair	

HEART / SMALL INTESTINE

☐ Heart Palpitations	☐ Restlessness / Agitation	
☐ Chest Pain	☐ Vivid Dreams	
☐ Insomnia / Sleep Problems	☐ Do you crave: Bitter	
☐ Trouble Falling Asleep		
☐ Trouble Staying Asleep		
How many times do you wake up?		
☐ Easily Startled		

LUNG / LARGE INTESTINE

☐ Bloody Cough	☐ Skin Rashes / Hives	☐ Black / Blood in Stools
☐ Dry Cough	☐ Snoring	☐ Constipation
☐ Nasal Discharge (check color)	☐ Grief / Sadness	☐ IBS
☐ White ☐ Yellow ☐ Green	☐ Shortness of Breath	☐ Colitis/ Spastic Colon

SYMPTOMS **NOTE: For each symptom you currently (leave blank if they do not apply)**

LUNG / LARGE INTESTINE CONT.

☐ Post Nasal Drip (check color)	☐ Allergies / Asthma	☐ Diarrhea
☐ White ☐ Yellow ☐ Green	☐ Low Resistance to Colds or Flu	
☐ Sinus Infection/ Congestion	☐ Sneezing	
☐ Itchy, Red, or Painful Throat	☐ Smokes Cigarettes	
☐ Dry Mouth/ Throat/ Nose	☐ Emphysema Bronchitis	

SPLEEN / STOMACH

☐ Heaviness Anywhere in the Body	☐ Bad Breath	☐ Abdominal Pain
☐ Fatigue	☐ Nausea/ ☐ Vomiting / ☐ Gas / ☐ Belching	☐ Indigestion / Heartburn
☐ Hard to get up in the Morning	☐ Hemorrhoids	☐ Over - Thinking
☐ Muscles Feel Tired Often	☐ Constipation	☐ Tendency to Gain Weight
☐ Edema (swelling) hands Feets	☐ Diarrhea	☐ Brain Foggy
☐ Easily Bruising & Bleeding	☐ Bowel Movements	☐ Do you Crave: Sweet

How many times do you go per day?

Do you feel done after you go?

☐ Yes ☐ No

ACUPUNCTURE AVENUE

FINANCIAL POLICY

The following is a statement of our financial policy, which we require you to read and sign prior to any treatment. Payment is expected as services are rendered. If you are covered by insurance, we expect payment for deductibles and co-payments on the date of service. We accept cash, check or credit cards.

Regarding insurance: We verify your insurance as a courtesy to you. HOWEVER, you are ultimately responsible for your payment of any co-pays/co-insurance. Insurance carriers can and do make mistakes when verifying coverage as such you may want to confirm your benefits and read your explanation of benefits as you receive them in the mail. In order to provide this service to you, we must have completed insurance information and confirmation of your coverage. If this information is not provided to us in a timely manner, we will be unable to bill your insurance company for you and you will be expected to pay in full for services rendered. If we have not received payment from your insurancemwithin 45 days of billing, the balance if a problem occurs. We expect all balances to be cleared in less than 45 days

Usual and customary rates: Our practice is committed to providing the best treatment and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates. Please keep in mind that we can only estimate what your insurance will pay since each insurance company has their specific limitations and exclusions.

Billing: For all accounts over 45 days with patient amounts due, there will be a finance charge of 1.5% per month. We assign all accounts over 120 days to a collection service for processing. You agree to pay any reasonable additional fees, including all collection agency, legal fees and/or court cost, necessary.

Cancellation policy: There will be a charge of $45.00 for any cancelling an appointment without a 24-hour notice or for failing to show for an appointment. If you reschedule your appointment, the charge is waived.

Signature Release and Assignment of Benefits:

My signature confirms the release of my authorization to Peter Yeung, LAc to have my signature as "signature on file" on my health insurance claim forms. **If my insurance carrier sends payments to me for services incurred with Peter Yeung, LAc, I agree to send or bring those payments to this office within 15 days upon receipt. I have read and agree to this financial policy and the agreements above.**

_____ _____

Patient or parent/guardian signature Date: