

PATIENT RECORD & MEDICAL HISTORY

Name _____ Birth Date _____ Today's Date _____

Home Address _____ City _____ State _____ Zip _____

Mobile Phone () _____ Other Phone () _____ Age _____ Gender _____

Email Address _____ Occupation _____

Social Security Number _____ How did you hear about us? _____ Referring Dr. _____

Relationship Status _____ How many children do you or your partner have? _____

Emergency Contact _____ Phone () _____

Medical History: *please check all of the boxes below that are now or have been a part of your personal health history*

	<i>Current</i>	<i>Past</i>		<i>Current</i>	<i>Past</i>		<i>Current</i>	<i>Past</i>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	Hypoglycemia	<input type="checkbox"/>	<input type="checkbox"/>
Abortion	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	Insomnia	<input type="checkbox"/>	<input type="checkbox"/>
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>	Irregular Menses	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Men's Health Issues	<input type="checkbox"/>	<input type="checkbox"/>
Angina (Chest Pain)	<input type="checkbox"/>	<input type="checkbox"/>	Digestive Problems	<input type="checkbox"/>	<input type="checkbox"/>	Musculoskeletal Injuries	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	Endocrine Problems	<input type="checkbox"/>	<input type="checkbox"/>	Neurological Problems	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Psychological Problems	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory Problems	<input type="checkbox"/>	<input type="checkbox"/>
Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Urogenital Problems	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Dry Eyes, Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Women's Health Issues	<input type="checkbox"/>	<input type="checkbox"/>

If you have a family history of any of these problems, please specify here:

Please list all past surgeries and approximate dates:

Please list all medications you are currently taking:

Chief Complaints: *please describe the major health concerns you would like to have addressed*

Please complete and sign the other side.

Please answer the following questions

Do you have a tendency to faint?	Yes	No	How frequently do you smoke? _____
Do you have a pacemaker?	Yes	No	How frequently do you drink coffee? _____
Do you bleed for a long time?	Yes	No	How frequently do you drink alcohol? _____
Have you ever had Hepatitis?	Yes	No	Do you follow a special diet? Specify _____
Are you HIV positive?	Yes	No	Approximately, how often do you get sick? _____
Are you pregnant?	Yes	No	What vitamins, herbs or nutritional supplements are you
Do you take birth control pills?	Yes	No	currently taking? _____
Do you exercise regularly?	Yes	No	_____

Our Office Policy

1. All fees for medical services are due at the time of visit unless previous arrangements have been made between East Bay Acupuncture & Natural Medicine and your insurance provider or other organization. Insurance is not a substitute for payment. It is your responsibility to pay any deductible amount, co-payment, or any other balance not paid by your insurance provider.

Initials _____

2. If you need to cancel your appointment, please inform us at least 24 hours prior to your appointment to avoid a late fee. A missed appointment or late cancellation (less than 24 hours notice) will result in you being charged the full treatment rate of \$75. This fee must be paid by you, and is not payable by insurance, worker's compensation or any other 3rd party.

Initials _____

3. There is a service charge of \$25 for every returned check.

Initials _____

4. Fees for Service are as follows (non-insurance, non-worker's compensation only):

New Patient Consultation (with acupuncture)	\$125
Return Patient Acupuncture	\$75
Established Patient Brief Consultation	\$35
Manual Therapy (15 minutes)	\$20
Herbs & Supplements (per week)	\$0 - \$50
6 pre-paid treatments (\$70 per session)	\$420
12 pre-paid treatments (\$65 per session)	\$780

Initials _____

1. 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.

2. If you are under 18 years of age, please have your parent or legal guardian sign below.

3. East Bay Acupuncture & Natural Medicine is required by law, to maintain the privacy and confidentiality of your protected health information. The policy is available for you to read in our waiting room or you can request a written copy.

I have read and agreed to the terms of the preceding paragraphs. All the information is true to the best of my knowledge.

Signature _____ Date _____

Please contact us with any questions or concerns:
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