Registration Form

Kimura Acupuncture

Today's Date: Patient #:

Patient Information

Patient's Last Name:	First Name:	Middle:	☐ Mr. ☐ Miss ☐ Mrs. ☐ Ms.
Street Address:	City:	State:	Zip:
Home Phone:	Birth Date: / /	Social Security Number:	
Work Phone:	Employer / Occupation:		Status: ☐ Single ☐ Married ☐ Other
Cell Phone:	Email Address:		
Primary Physician's Name:	Primary Physician's Phone:		Can I contact him/her? ☐ Yes ☐ No

Chose clinic because/Referred to clinic by (please check one box):

☐ Dr. _____ ☐ Family ☐ Friend ☐ Hospital ☐ Close to home / work

☐ Yellow Pages ☐Other (Please specify:)

Insurance Information

Please give your insurance card to the receptionist.

Name of Primary Insurance:		Subscriber's Name:
Group Number:	Policy Number:	Subscriber's Social Security Number:
Subscriber's Birth Date / /	Co-Payment $	Patient's Relationship to Subscriber:
Name of Secondary Insurance:		Subscriber's Name:
Group Number:	Policy Number:	Subscriber's Social Security Number:
Subscriber's Birth Date / /	Co-Payment $	Patient's Relationship to Subscriber:

In Case of Emergency

Name of Friend or Relative:	Home Phone:	Work or Cell Phone:

The above information is true to the best of my knowledge. I agree to pay the reduced fee of $100 for initial treatment and $80 per follow-up treatment (or $40 per auricular acupuncture treatment only) due to financial difficulties if my insurance does not cover acupuncture treatments.

Signature Date