

# Registration Form

Kimura Acupuncture

Today's Date:

Patient #:

Patient Information				
Patient's Last Name:	First Name:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Miss	<input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.
Street Address:	City:	State:	Zip:	
Home Phone:	Birth Date: / /	Social Security Number:		
Work Phone:	Employer / Occupation:		Status:	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Other
Cell Phone:	Email Address:			
Primary Physician's Name:	Primary Physician's Phone:		Can I contact him/her? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Chose clinic because/Referred to clinic by (please check one box):				
<input type="checkbox"/> Dr. _____ <input type="checkbox"/> Family <input type="checkbox"/> Friend <input type="checkbox"/> Hospital <input type="checkbox"/> Close to home / work				
<input type="checkbox"/> Yellow Pages <input type="checkbox"/> 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 \_\_\_\_\_