Great Lakes Acupuncture

Charlene X. Jiang

Certified Acupuncturist

PATIENT INFORMATION SHEET

(Please Print)

Patient Name ____

(Last) (First) (Middle)

Address____

City ______________________________ State____________________ Zip ________________

Home Phone ____________________ Text: Y or N _____ Business Phone__________________________

Email: ______________________________@____

PLEASE CIRCLE HOW YOU WOULD LIKE A REMINDER TO BE SENT: PHONE Y N TEXT Y N Email Y N

Date of Birth ___________________ Sex: **M** or **F** Marital Status: Single Married Other

Social Security # ______________________ Occupation ___________________________________

Patient Employed By____

Emergency Contact Name ________________________ Emergency Phone______________________

Physician's Name ______________________________ Phone Number _________________________

Physician's Diagnosis ____

How were you referred to us ____

Insurance Company ____

AUTHORIZATION:

I authorize the release of any medical information necessary to process my insurance and I understand that I am responsible for any amount not covered by my insurance.

Signature ____ Date ________________