Troy Acupuncture

Med #:

Last Name: ____ First Name: _________________________________

Age: _____ Date of Birth: ______/______/______ Drivers License #: ____________

Male: ☐ Female: ☐

Home Address: ____ Apt/ Suite #: ____________

City: ___________________________ State: __________ Zip: __________

Home Number #: (_______)____________________ Cell #: (_______)________________________

Occupation: __________________________ Employer: __________________________

Work Address: _____________________________________ City: _______________ State: ______ Zip: _______

Spouse's Name: ____ Phone #: _______________________

E-mail Address: ____

Chief Complaint: ____

Please Answer the Following Questions Circling Yes/No

Do you have a tendency to faint?: Yes No

Do you have a pacemaker?: Yes No

Do you bleed for a long time?: Yes No

Have you had hepatitis?: Yes No

Are you HIV positive?: Yes No

Are you pregnant (females)?: Yes No

What medication(s) are you on now?: ________
____
____

Insurance Information:
(For health insurance form completion purposes)

Name of insurance co: __________________________ Insured's Name: ___________________

Insurance ID #: ____________________ Insured Date of Birth ______/______/______ Relation: _______

Emergency contact:

Name: ________________________ Relation: __________________ Phone: (_______)_________________

Primary Physician's Name: ________________________ Phone Number: (_______)_____________________

Referred By:

Name: _______________________________________ Referral Phone #: (______)______________________

Referral Address: _______________________________

Other: ☐ Google: ☐ Acufinder.com: ☐ Askdrmao.com: ☐ taoofwellnesss.com: ☐

If you are under 18 years of age, please have your parent or legal guardian sign below.
I have read and agree to the terms above. All of the information is true to the best of my knowledge.

X______________________________________ Date: ______/______/______/
Signature of Patient/Parent/ Legal Guardian

X______________________________________ Relation: _______________________________
Printed Name of Patient/ Parent/ Legal Guardian

(248) 528-1688
2073 E Maple Road Troy, MI 48083