John Golden ACUPUNCTURE

9295 E. Stockton Blvd., Elk Grove, CA 95624 ● (916) 685-6380

NEW PATIENT REGISTRATION FORM

To help us provide you with the best possible care, please fill out this form **as accurately as possible**. All personal information will be kept ***confidential*** in your patient file.

Full Name: _____ **Birth Date:** / / **Gender: M / F**

Social Security # _____-_____-_____ Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Other

Street Address _____

City _____ State _____ Zip _____

Phone (Home) (_____)_____-_____ Phone (Work) (_____)_____-_____

E-mail _____ Phone (Cell) (_____)_____-_____

Employer _____ Occupation _____

EMERGENCY CONTACT

In case of emergency, whom should we contact? Name _____

Relationship _____ Phone (_____)_____-_____

OTHER HEALTHCARE PROVIDERS

Primary Physician _____ Phone (_____)_____-_____

Other healthcare practitioner you see regularly:

Name _____ Type of Practitioner _____

REFERRAL INFORMATION

How did you hear about John Golden Acupuncture? _____

MEDICAL HISTORY

Please check the boxes below that are now or have been a part of your personal health history.

	Current	Past		Current	Past		Current	Past
Addiction	❑	❑	Digestive Disorders	❑	❑	Insomnia	❑	❑
Specify: _____			Emotional Disorders	❑	❑	Irregular Pregnancy	❑	❑
Arthritis	❑	❑	Emphysema	❑	❑	Menstrual Irregularity	❑	❑
Abortion	❑	❑	Epilepsy	❑	❑	STD	❑	❑
Anemia	❑	❑	Headaches/Migraines	❑	❑	Skin Problems	❑	❑
Asthma	❑	❑	Heart Attack	❑	❑	Tuberculosis	❑	❑
Blood Pressure - High	❑	❑	Heart Disease	❑	❑	Ulcer	❑	❑
Blood Pressure - Low	❑	❑	Hepatitis	❑	❑	Urinary Tract Infection	❑	❑
Blood Transfusion	❑	❑	Type: A ____ B ____ C ____			Vaginal Infection	❑	❑
Bronchitis	❑	❑	Heavy Bleeding	❑	❑	Other	❑	❑
Cancer	❑	❑	High Cholesterol	❑	❑	Specify: _____		
Chronic Fatigue	❑	❑	HIV+	❑	❑	Other	❑	❑
Diabetes	❑	❑	Hypoglycemia	❑	❑	Specify: _____		

CHIEF COMPLAINT - Please briefly describe your major wellness concern:

PLEASE TURN OVER – COMPLETE AND SIGN THE OTHER SIDE

Please list any **MAJOR ACCIDENTS**, **SURGERIES**, OR **HOSPITALIZATIONS**:

Incident:	Date:

ALLERGIES – Please list ANY allergic reactions you have had (medications, foods, plants, animals, etc.)

Substance:	Reaction:	Substance:	Reaction:

FAMILY HISTORY – Check any conditions that have been present in blood relatives:

❑ Cancer ❑ Stroke ❑ Diabetes ❑ Heart Problems ❑ High Blood Pressure ❑ Other: _____

LIFESTYLE FACTORS – Which of the following are a part of your lifestyle?

❑ Tobacco ❑ Coffee ❑ Alcohol ❑ Recreational Drugs ❑ Exercise ❑ Special Diet: _____

MEDICATIONS & SUPPLEMENTS – Please list all medications, herbs, and nutritional supplements you take.

Substance:	Dosage:	Substance:	Dosage:	Substance:	Dosage:

OFFICE POLICIES:

All fees for goods and services are due at the time of visit unless prior arrangements have been made in writing. Acceptable forms of payment are cash, check, and credit card. To minimize administrative costs we do not file insurance paperwork, but upon request will provide you with a Superbill which you can submit to your insurance company.

If you need to cancel an appointment, please give a minimum of 24 hours notice. There may be a cancellation fee of an amount up to the full cost of the missed treatment session for less than 24-hour notification.

Please Initial Here: _____

✓ I certify that, to the best of my knowledge, the information I have provided herein is accurate and correct.

✓ My signature authorizes the Practitioner named on this form to treat me (or the patient for whom I am legally responsible) with acupuncture, Chinese medicinal herbs, and massage within the licensure granted by the Medical Quality Assurance Board of the State of California and the California Acupuncture Committee.

✓ 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.

✓ I have received a copy of the office Notice of Privacy Policies.

Signature _____ Date _____

(Patient, Parent, or Guardian)

FOR OFFICE USE ONLY:

Witness to Patient's Signature _____ Date _____

(Staff or Acupuncturist)