SHANGHAI ACUPUNCTURE SERVICES, PC

101 Greenwich Street, Suite 1506, New York, NY 10006
Tel: (212) 374-0169 Fax: (212) 374-0457

PATIENT INFORMATION

Name:_____ Date of Birth:_____ Age:_____

Sex: [M] [F] Marital Status: [S] [M] [W] [D] Social Security Number:_____

Address:_____ City:_____ State:_____ ZIP:_____

Telephone (H):_____ (W):_____ Occupation:_____

Referred By:_____ Insurance Company:_____

Policy Number:_____ Tel:_____

Please answer the following questions:

1) Do you have high blood pressure?---------- Yes No
2) Do you have any heart problems?---------- Yes No
3) Do you have diabetes?---------- Yes No
4) Do you have hepatitis?---------- Yes No
5) Do you have AIDS or HIV+?---------- Yes No
6) Do you have hemophilia?---------- Yes No
7) (Woman) Are you pregnant at the present time?---------- Yes No
8) Have you ever had acupuncture treatment?---------- Yes No
9) Please list any allergies_____
10) Please list any medications you are taking_____
11) Please list your reason(s) for this visit _____
_____

***** Patients must give 24 hours notice of cancellation or payment for appointment will be expected.**

We, the undersigned, do affirm that (the patient) _____ had been advised by China Acupuncture Services, PLLC to consult a physician regarding the condition or conditions for which such patient seeks acupuncture.

_____ _____
Signature (Patient) Date

_____ _____
Signature (Acupuncturist) Date