CHINA ACUPUNCTURE SERVICES, PLLC

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Mt. Kisco, NY 10549
Tel: (914) 666-0100
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PATIENT INFORMATION

Name:________________________________Date of Birth:________________Age:_________

Sex:_____ Marital Status:_________ Social Security Number:___________________________

Address:_______________________________ City:_______________ State:___ Zip:________

Telephone (H):_________________ (B): _________________ 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 problem?-- 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) Are you (woman) 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)________________________________has been advised by China Acupuncture Services, PLLC to consult a physician regarding the condition(s) for which such patient seeks acupuncture.

______________________________________ Signature (patient)

__________________ Date

______________________________________ Signature (acupuncturist)

__________________ Date