ZOEACUPUNCTURE
PATIENT REGISTRATION FORM

PLEASE PRINT	PLEASE COMPLETE ALL INFORMATION	PLEASE PRINT

PATIENT – This section refers to patient only **TODAY'S DATE:**_____/_____/_____

LAST NAME	FIRST	MI	SEX M F	AGE	BIRTH DATE	MARITAL STATUS (X ONE)
						☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

MAILING ADDRESS	SOCIAL SECURITY #

CITY	STATE	ZIP CODE	EMPLOYER	OCCUPATION

EMAIL ADDRESS	EMPLOYER ADDRESS	WORK PHONE
		( )

HOME PHONE	CELL PHONE	CITY	STATE	ZIP CODE
( )	( )			

INSURANCE (PRESENT ID CARDS FOR PHOTO COPYING)

PRIMARY INSURANCE	SECONDARY INSURANCE
POLICY #	POLICY #
GROUP_____ EFFECTIVE DATE_____	GROUP_____ EFFECTIVE DATE_____
POLICY OWNER NAME	POLICY OWNER NAME
POLICY OWNER SS# D.O.B.	POLICY OWNER SS# D.O.B.

PAYMENT FOR SERVICES:
I clearly understand and agree that all services rendered to me charged directly to me and I am responsible for the payment. Zoe Meininger, LAc. may as a courtesy bill my insurance for her services, in that case I agree to bring all the checks issued for those services directly to Zoe Meininger, LAc. or her staff, or write them a check of equal value. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me or my dependent will be immediately due and payable.

Initials:_____

INFORMED CONSENT:
I hereby request and consent to the performance of acupuncture, herbal/nutritional therapy and other therapeutic procedures and modalities, including, but not limited to various modes of physical therapy and diagnostic procedures on me by Zoe Meininger, L.Ac., and/or any other licensed physician who may treat me while employed by, working for or associated with or serving as backup for Zoe Meininger, L.Ac. I have had the opportunity to discuss with Zoe Meininger, L.Ac. the nature and purpose of Acupuncture treatments and other procedures and modalities. I understand that progress in my treatment may vary according to my condition. I understand and am informed that, in the practice of acupuncture there are some risks to treatment. I do not expect Zoe Meininger, L.Ac. to be able to anticipate and explain all risks and complications, and I wish to rely on her to exercise judgment during the course of the treatment, which she feels at the time, based upon then known, is in my best interests.

Initials:_____

IN CASE OF EMERGENCY NOTIFY: NAME (COMPLETE)	RELATIONSHIP	WORK PHONE	HOME PHONE

WHO MAY WE THANK FOR REFERRING YOU TO ZOEACUPUNCTURE?

PRIMARY CARE PHYSICIAN: PHONE:

DO WE HAVE YOUR PERMISSION TO LEAVE MESSAGES ON YOUR VOICE MAIL REGARDING PERSONAL MEDICAL INFORMATION?

(CHECK ONE) ☐ YES ☐ NO

IF YES, AT WHICH PHONE NUMBER MAY WE LEAVE A PERSONAL MESSAGE (CHECK ONE OR BOTH) ☐ HOME ☐ CELL