PATIENT REGISTRATION AND MEDICAL HISTORY

Name: Last	First		Date:	
Address:	City:	State:	Zip:	
Phone: [home]	[cell]	Email:		
Preferred contact phone for appointment messages:				
Birth Date:	Age:	Birth Place:	Height	Weight
Status: Single	In relationship	Married		
Spouse Name: Last	First		Spouse Birthdate:	
No. of children	Employer:		Occupation:	
How did you find out about us?		Referred By:		
Emergency contact:	Contact telephone #		Relationship to you	

HAVE YOU EVER HAD ACUPUNCTURE? ☐ Yes ☐ No For what reason?_____

MAJOR SURGERIES, HOSPITIAZATIONS, X-RAYS, MRI'S…

(If you have ever been hospitalized for any serious medical illness, procedures or surgical operations)

Date	Operation, Procedure or Illness	Name of Hospital

LIST ALL MEDICATION YOU ARE CURRENTLY TAKING

Medication	**For what condition**	**Dosage**

FEMALES ONLY:

Pregnant? ☐ Yes ☐ No **Menses:** Length of Cycle_____Days

Flow: Light Heavy Normal **Duration**:_____Days

PERSONAL HABITS

☐ Smoking ☐ Alcohol Vegetarian

PLEASE LIST YOUR TOP 3 HEALTH CONCERNS THAT HAVE BROUGHT YOU HERE IN ORDER OF IMPORTANCE
What would you like to be treated for? (Describe briefly. How long have you had it for? How does it affect you? What treatments have you had before and what was the result?
1.
2.
3.

Do you have silver fillings in your teeth?	☐	Yes	☐	No	Approx. how many teeth are affected ?
Are you interested in the following?					
☐	Healing for past traumas and memories				
☐	Meditation / Breathing excercise				

Cancellation Policy: There is a $45 fee for any cancellations, no shows and rescheduled appointments without a 24-hour notice.

Signature: _____ Date: _____

SYMPTOMS — **NOTE: For each symptom you currently (leave blank if they do not apply)**

LIVER / GALLBLADDER

- ☐ Irritability
- ☐ Anger
- ☐ Depression
- ☐ Stress
- ☐ Headaches / Migraines
- ☐ Visual Problems
- ☐ Red / Dry / Itchy Eyes
- ☐ Gall Stones
- ☐ Dizziness
- ☐ Blurred Vision
- ☐ Feeling of Lump in Throat
- ☐ Clenching of Teeth at Night
- ☐ Muscle Cramping / Twitching
- ☐ Tension
- ☐ Poor Circulation
- ☐ Soft / Brittle Nails
- ☐ Emotional Eater
- ☐ Bad Taste in Mouth
- ☐ Bad Breath
- ☐ Do you Crave: Sour

KIDNEY/ URINARY BLADDER

- ☐ Urinary Problems Bladder
- ☐ Infection Dropped Bladder
- ☐ Incontinence
- ☐ Lack of Bladder Control
- ☐ Weakness
- ☐ Pain in Lower Back
- ☐ Decrease Bone Density
- ☐ Feel Cold Easily
- ☐ Cold Hands
- ☐ Cold Feet
- ☐ Low Sex Drive / Libido
- ☐ Excess Sexual Desire
- ☐ Poor Memory
- ☐ Loss of Hair
- ☐ Hearing Problems
- ☐ Cavities
- ☐ Fear
- ☐ Hot Flash/ Night Sweating
- ☐ Do you crave: Salty

HEART / SMALL INTESTINE

- ☐ Heart Palpitations
- ☐ Chest Pain
- ☐ Insomnia / Sleep Problems
- ☐ Easily Startled
- ☐ Restlessness / Agitation
- ☐ Vivid Dreams
- ☐ Do you crave: Bitter

LUNG / LARGE INTESTINE

- ☐ Bloody Cough
- ☐ Dry Cough
- ☐ Nasal Discharge (check color)
  ☐ White ☐ Yellow ☐ Green
- ☐ Post Nasal Drip (check color)
  ☐ White ☐ Yellow ☐ Green
- ☐ Sinus Infection/ Congestion
- ☐ Itchy, Red, or Painful Throat
- ☐ Dry Mouth/ Throat/ Nose
- ☐ Skin Rashes / Hives
- ☐ Snoring
- ☐ Grief / Sadness
- ☐ Shortness of Breath
- ☐ Allergies / Asthma
- ☐ Low Resistance to Colds or Flu
- ☐ Sneezing
- ☐ Mild Fever Comes & goes
- ☐ Smokes Cigarettes
- ☐ Emphysema Bronchitis
- ☐ Black / Blood in Stools
- ☐ Constipation
- ☐ IBS
- ☐ Colitis/ Spastic Colon
- ☐ Diarrhea

SPLEEN / STOMACH

- ☐ Heaviness Anywhere in the Body
- ☐ Fatigue
- ☐ Hard to get up in the Morning
- ☐ Muscles Feel Tired Often
- ☐ Edema (swelling) hands Feets
- ☐ Easily Bruising & Bleeding
- ☐ Bad Breath
- ☐ Nausea/ Vomiting
- ☐ Nausea/ Vomiting/ Gas / Belching
- ☐ Hemorrhoids
- ☐ Constipation
- ☐ Diarrhea
- ☐ Abdominal Pain
- ☐ Indigestion / Heartburn
- ☐ Over - Thinking
- ☐ Tendency to Gain Weight
- ☐ Brain Foggy
- ☐ Do you Crave: Sweet

ACUPUNCTURE AVENUE

FINANCIAL POLICY

The following is a statement of our financial policy, which we require you to read and sign prior to any treatment. Payment is expected as services are rendered. If you are covered by insurance, we expect payment for deductibles and co-payments on the date of service. We accept cash, check or credit cards.

Regarding insurance: We verify your insurance as a courtesy to you. HOWEVER, you are ultimately responsible for your payment of any co-pays/co-insurance. Insurance carriers can and do make mistakes when verifying coverage as such you may want to confirm your benefits and read your explanation of benefits as you receive them in the mail. In order to provide this service to you, we must have completed insurance information and confirmation of your coverage. If this information is not provided to us in a timely manner, we will be unable to bill your insurance company for you and you will be expected to pay in full for services rendered. If we have not received payment from your insurancemwithin 45 days of billing, the balance if a problem occurs. We expect all balances to be cleared in less than 45 days

Usual and customary rates: Our practice is committed to providing the best treatment and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates. Please keep in mind that we can only estimate what your insurance will pay since each insurance company has their specific limitations and exclusions.

Billing: For all accounts over 45 days with patient amounts due, there will be a finance charge of 1.5% per month. We assign all accounts over 120 days to a collection service for processing. You agree to pay any reasonable additional fees, including all collection agency, legal fees and/or court cost, necessary.

Cancellation policy: There will be a charge of $45.00 for any cancelling an appointment without a 24-hour notice or for failing to show for an appointment. If you reschedule your appointment, the charge is waived.

Signature Release and Assignment of Benefits:

My signature confirms the release of my authorization to Peter Yeung, LAc to have my signature as "signature on file" on my health insurance claim forms. **If my insurance carrier sends payments to me for services incurred with Peter Yeung, LAc, I agree to send or bring those payments to this office within 15 days upon receipt. I have read and agree to this financial policy and the agreements above.**

_____ _____

Patient or parent/guardian signature Date:

Patient Advisory and Acknowledgment

Receiving Medical Treatment During the COVID-19 Pandemic

Dear Patient:

You have come to our office today for a routine medical evaluation and/or treatment that will be done during the COVID-19 pandemic. Please be advised of the following:

> While our office complies with State Health Department and the Centers for Disease Control and Prevention infection control guidelines to prevent the spread of the COVID-19 virus, we cannot make any guarantees.
>
> Our staff are symptom-free and, to the best of their knowledge, have not been exposed to the virus. However, since we are a place of public accommodation, other persons (including other patients) could be infected, with or without their knowledge.

In order to reduce the risk of spreading COVID-19, we have asked you a number of "screening" questions below. For the safety of our staff, other patients, and yourself, please be truthful and candid in your answers.

PATIENT/RESPONSIBLE PARTY _____ DATE _____

PLEASE ANSWER "YES" OR "NO" WITH YOUR INITIALS, TO THE FOLLOWING QUESTIONS:

HAVE YOU BEEN DIAGNOSED POSITIVE FOR THE COVID-19 VIRUS AT ANY TIME?	_____ YES	_____ NO
ARE YOU CURRENTLY AWAITING THE RESULTS OF A COVID-19 TEST?	_____ YES	_____ NO
DO YOU HAVE A FEVER?	_____ YES	_____ NO
DO YOU HAVE ANY SHORTNESS OF BREATH?	_____ YES	_____ NO
DO YOU HAVE A DRY COUGH?	_____ YES	_____ NO
DO YOU HAVE A RUNNY NOSE?	_____ YES	_____ NO
DO YOU HAVE A SORE THROAT?	_____ YES	_____ NO
DO YOU HAVE SNEEZING, WATERY EYES, AND/OR SINUS PAIN/PRESSURE THAT IS UNUSUAL AND NOT RELATED TO SEASONAL ALLERGIES?	_____ YES	_____ NO
HAVE YOU EXPERIENCED HEADACHES, FATIGUE, OR WEAKNESS?	_____ YES	_____ NO
HAVE YOU LOST YOUR SENSE OF TASTE AND/OR SMELL?	_____ YES	_____ NO
WITHIN THE LAST 14 DAYS, HAVE YOU TRAVELLED TO ANY FOREIGN COUNTRY?	_____ YES	_____ NO
WITHIN THE LAST 14 DAYS, HAVE YOU TRAVELLED WITHIN THE UNITED STATES OR TO ANY FOREIGN COUNTRY?	_____ YES	_____ NO

IF SO, WHERE? _____