New Destination Acupuncture

9 Legacy Way, Suite A., Adairsville, GA 30103 | Phone: 404-680-0671 | Fax: 404-689-0660

NEW PATIENT INTAKE

Client Name (First/Middle/Last): _____

Address:_____

_____

Home Phone #: _____ Cell Phone #: _____ Work Phone #: _____

Preferred E-mail Address: _____

Date of Birth: _____ Gender: _____ Height:_____ Weight:_____ Veteran's ID: _____

How did you become aware of New Destination Acupuncture? _____

Do you have previous experience with Acupuncture? _____

Emergency Contact Information:

Name: _____ Relationship:_____

Address:_____

_____

Home Phone #: _____ Cell Phone #: _____

Email: _____

Employment Contact Information:

Employer: _____ Phone #: _____

Primary Physician Contact Information:

Physician: _____ Phone #: _____

Medical Information:

What is the primary reason for your visit today? _____

_____

List any other health concerns: _____

_____

List current medications (Rx & OTC) and supplements: _____

_____

List all hospitalizations and surgeries: _____

_____

List known allergies: _____

_____

Father's Overall Health: Good / Fair / Poor Age of Death:_____ Cause of Death: _____

Mother's Overall Health: Good / Fair / Poor Age of Death:_____ Cause of Death: _____

Please also SIGN the Authorization to Contact on the Reverse Side of this Form.

New Destination Acupuncture

9 Legacy Way, Suite A., Adairsville, GA 30103 | Phone: 404-680-0671 | Fax: 404-689-0660

Authorization to Contact

I, _____, authorize New Destination Acupuncture to contact me and leave messages for me at my phone numbers and email addresses above/on the front.

Authorization to Release of Medical Information / Assignment of Benefits for Insurance Claims

If applicable, I, _____, authorize release of medical information necessary to process and pay insurance benefit claims and authorize direct pay of my medical benefits (e.g., insurance claim reimbursements, etc.) to the provider/New Destination Acupuncture from my insurance provider(s). I understand that I am responsible to pay all non-insurance related fees when services are rendered, including herbs, etc. if I choose to use my insurance, I understand I will be responsible for all "non-covered" services and/or coinsurance/copays associated with my office visit.

Signature of Client or Parent /Legal Guardian/ Legaly Responsible Person

---

Description of Relationship to Client (e.g., Self/ Parent / Legal Guardian / Legally Responsible Person)

Date