

Acupuncture and Chinese Medicine Clinic
9301 Linder Wy NW, #101, Silverdale, WA 98383
(360) 692-7000 www.tcmcenter.com

(Please Print)

Date ____/____/____

Personal Information

Last Name: _____ First Name: _____ Middle: _____
Street: _____ Apt: _____ or P.O. BOX: _____
City: _____ State: _____ Zip Code: _____
Home Phone: (_____) _____ - _____ Work Phone: (_____) _____ - _____
Email: _____
Emergency Contact: _____ Phone: (_____) _____ - _____
Date of Birth: _____
Age: _____ Sex: M / F Marital Status: S M W D Sep
Number of Children: _____
Primary Physician: Dr. _____

Working and Insurance Information

Employed by: _____ Occupation: _____
Insurance Co. _____ Plan/Group: _____
Policy ID#: _____ Co-pay\$: _____ Deductible\$: _____
Relationship to insured: Self Spouse Child Other
Information on insured (If other than yourself)
Name: _____ Date of Birth: _____
Address: _____ Phone Number: _____
Employer: _____
Secondary Insurance: (if covered by more than one) _____
Policy ID#: _____

Whom may we thank for referring

Referred by: _____
Advertisement in: _____
Other: _____

Patient's Name: _____

Date: ____/____/____

Health Related Information

Please list the main problems that you are having, or reasons for this appointment:

Have you seen other health care providers for this? (If yes, please list the diagnosis and treatments)

Medical History

Serious Illnesses: _____

Surgery: _____

Major accidents: _____

Current medications: _____

Current supplements/Herbs: _____

Others: _____

Allergies (Medications, Food and Environment etc):

Habits (Coffee, Tobacco, Alcohol and Drugs etc) or Special diet and exercises:

HIV positive: (yes) ____ (no) ____

Any other problems would you like to discuss:

Patient's Name: _____

Date: ____/____/____

Informed Consent to Acupuncture & Chinese Medicine Treatment

Washington law requires that each patient be informed regarding the scope of practice in which a licensed acupuncturist is allowed to engage. Acupuncture and Chinese Medicine Clinic practice includes: use of acupuncture needles and electric stimulus to stimulate acupuncture points and meridians; acupressure; dermal friction technique; infra-red heat treatment; cupping, Chinese herbs and dietary advice based on Traditional Chinese Medicine.

Side effects may occur in a small percentage of patients and may include the following:

some pain following treatment in the treated area, minor bruising or bleeding, infection, needle sickness (fainting), and broken needle. **If you have a severe bleeding disorder, have a pacemaker, or you are pregnant, please let your provider know prior to treatment.**

Financial Policy

Health and accident insurance policies are arrangements between an insurance carrier and yourself. Your provider will prepare necessary reports and forms to assist you in receiving the coverage by your insurance company for the treatment. Any co-payment required by your insurance company or payment for non-insured patient is expected at the time of the visit.

Confidential Policy

Acupuncture and Chinese Medicine Clinic keeps a record of the health care services that the provider renders to you. We will not disclose your records to others unless you direct us to do so, or the law authorizes, or compels us to do so.

Patient Consent

I read the above information and agree that I am well informed regarding the treatments provided by my provider and had an opportunity to ask questions about them. I also understand that I am responsible to pay all services rendered to me that my insurance carrier does not cover. By signing below, I agree to receive the treatments. I understand that my consent covers the entire course of treatment for my present condition and for any future conditions for which I seek treatment from my provider.

Patient Signature: _____

Date: _____

Parent or guardian Signature: _____