

## Registration Form

Kimura Acupuncture

Today's Date:

Patient #:

Patient Information			
Patient's Last Name:	First Name:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Miss <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.
Street Address:	City:	State:	Zip:
Home Phone:	Birth Date: / /	Social Security Number:	
Work Phone:	Email Address:		
Cell Phone:	Employer / Occupation:		
Chose clinic because/Referred to clinic by (please check one box): <input type="checkbox"/> Dr. _____ <input type="checkbox"/> Family <input type="checkbox"/> Friend <input type="checkbox"/> Hospital <input type="checkbox"/> Close to home / work <input type="checkbox"/> Yellow Pages <input type="checkbox"/> Other (Please specify: _____ )			

## Insurance Information

Please give your insurance card to the receptionist.

Name of Primary Insurance:		Subscriber's Name:
Group Number:	Policy Number:	Subscriber's Social Security Number:
Subscriber's Birth Date / /	Co-Payment \$	Patient's Relationship to Subscriber:
Name of Secondary Insurance:		Subscriber's Name:
Group Number:	Policy Number:	Subscriber's Social Security Number:
Subscriber's Birth Date / /	Co-Payment \$	Patient's Relationship to Subscriber:

## In Case of Emergency

Name of Friend or Relative:	Home Phone:	Work or Cell Phone:
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The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the acupuncturist. I understand that I am financially responsible for any balance. I also authorize Kimura Acupuncture or insurance company to release any information required to process my claims. I agree that I will pay the reduced fee of \$80 per treatment (or \$40 per auricular acupuncture treatment only) due to financial difficulties if my insurance does not cover acupuncture treatments.

Signature \_\_\_\_\_

Date \_\_\_\_\_