

# Acupuncture 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:	
Cell Phone"	Email Address:		
Occupation:	Employer:		
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: _____ )			
Other family members seen here:			

In Case of Emergency		
Name of Local Friend or Relative:	Relationship to Patient:	Home Phone:
		Work Phone:

The above information is true to the best of my knowledge. I agree to pay \$150 for an initial treatment and \$120 for a follow-up treatment.

Signature

Date