Registration Form

Kimura Acupuncture

Today's Date: Patient #:

Patient Information			
Patient's Last Name:	First Name:	Middle:	! Mr. ! Miss ! Mrs. ! Ms.
Street Address:	City:	State:	Zip:
Home Phone:	Birth Date: / /	Social Security Number:	
Work Phone:	Employer / Occupation:		Status: ! Single ! Married ! Other
Cell Phone:	Email Address:		
Primary Physician's Name:	Primary Physician's Phone:		Can I contact him/her ! Yes ! No
Chose clinic because/Referred to clinic by (please check one box): ! Dr. _____ ! Family ! Friend ! Hospital ! Close to home / work ! Yellow Pages ! 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:

The above information is true to the best of my knowledge. I agree to pay the reduced fee of $120 for initial treatment and $90 per follow-up treatment due to financial difficulties if my insurance does not cover acupuncture treatments.

Signature Date

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