Patient Information

Date_____

E-mail_____

Patient Name_____

Address_____

City_____ State_____ Zip _____

Sex: M☐ F☐ Birthdate_____ Age_____

Married☐ Widowed☐ Single☐ Minor☐

Separated☐ Divorced☐ Partnered for___ years

What type of case will this be: ILWU-Kaiser☐ ILWU-PPO☐

Other Insurance☐ Work Comp☐ Cash☐

Patient Employer/ School_____

Occupation_____

Employer/ School Address_____

_____

Employer/ School Phone (___) _____

Spouse's Name_____

Birthdate_____

SS#_____

Spouse's Employer_____

Whom may we thank for referring you?_____

Insurance Information

Who is responsible for this account?_____

Relationship to Patient _____

Insurance Co. _____

Group #_____

Is patient covered by additional insurance? Y☐ N☐

Subscriber's Name _____

Birthdate _____ SS#_____

Relationship to patient_____

Insurance Co. _____

Group #_____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to GREEN HEALTH ACUPUNCTURE all insurance benefits, if any, otherwise payable to me for the services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named facility may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

Signature_____

Print Name _____

Date_____ Relationship to Patient_____

Phone Numbers

Cell (___) _____ Home (___) _____

Work (___) _____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT

Name_____ Relationship _____

Home(___)_____ Work (___) _____

Accident Information

Is condition due to an accident? Y☐ N☐ Date _____

Type of accident: auto☐ work☐ home☐ other_____

To whom have you made a report of your accident?

auto insurance____ employer____

worker comp_____ other_____

Attorney Name(if applicable)_____

Patient Condition

Reason for Visit _____

When did symptoms appear?_____

Is this condition getting progressively worse? Yes☐ No☐ Unknown____

Rate the severity of your pain on a scale from 1(least pain) to 10 (severe pain) _____

Type of pain: sharp☐ dull☐ throbbing☐ numbness☐ aching☐ shooting☐
burning☐ tingling☐ cramps☐ stiffness☐ swelling☐ other_____

How often do you have this pain? _____Is it constant or does it come and go? _____

Does it interfere with your: work☐ sleep☐ daily routine☐ recreation☐

Activites or movements that are painful to perform: sitting☐ standing☐ walking☐ bending☐ lying down☐

Health History

What treatment have you already received for your condition? Medications ☐ Surgery ☐ Acupuncture ☐

Physical therapy ☐ Chiropractic ☐ None ☐ Other _____

Name and address of other doctor(s) who have treated you for your condition _____

_____

Date of last: Physical Exam _____ Spinal X-Ray _____ Blood Test _____

Spinal Exam _____ Chest X-Ray _____ Urine Test _____

Dental X-Ray _____ MRI, CT-Scan, Bone Scan _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	☐Yes ☐No	Goiter	☐ Yes ☐No	Pneumonia	☐Yes ☐No
Alcoholism	☐Yes ☐No	Gonorrhea	☐ Yes ☐No	Polio	☐Yes ☐No
Allergy Shots	☐Yes ☐No	Gout	☐ Yes ☐No	Prostate problem	☐Yes ☐No
Anemia	☐Yes ☐No	Heart disease	☐ Yes ☐No	Prosthesis	☐Yes ☐No
Anorexia	☐Yes ☐No	Hepatitis	☐ Yes ☐No	Psychiatric care	☐Yes ☐No
Appendicitis	☐Yes ☐No	Hernia	☐ Yes ☐No	Rheumatoid arthritis	☐Yes ☐No
Arthritis	☐Yes ☐No	Herniated disk	☐ Yes ☐No	Rheumatic fever	☐Yes ☐No
Asthma	☐Yes ☐No	Herpes	☐ Yes ☐No	Scarlet fever	☐Yes ☐No
Bleeding disorders	☐Yes ☐No	High blood pressure	☐ Yes ☐No	Sexually transmitted diseases	☐Yes ☐No
Breast lump	☐Yes ☐No	High cholesterol	☐ Yes ☐No	Stroke	☐Yes ☐No
Bronchitis	☐Yes ☐No	Kidney disease	☐ Yes ☐No	Suicide attempt	☐Yes ☐No
Bulimia	☐Yes ☐No	Liver disease	☐ Yes ☐No	Thyroid problems	☐Yes ☐No
Cancer	☐Yes ☐No	Measles	☐ Yes ☐No	Tonsillitis	☐Yes ☐No
Cataracts	☐Yes ☐No	Migraine headaches	☐ Yes ☐No	Tuberculosis	☐Yes ☐No
Chemical dependency	☐Yes ☐No	Miscarriage	☐ Yes ☐No	Tumors, growths	☐Yes ☐No
Chicken pox	☐Yes ☐No	Mononucleosis	☐ Yes ☐No	Typhoid fever	☐Yes ☐No
Diabetes	☐Yes ☐No	Mumps	☐ Yes ☐No	Ulcers	☐Yes ☐No
Emphysema	☐Yes ☐No	Osteoporosis	☐ Yes ☐No	Vaginal infections	☐Yes ☐No
Epilepsy	☐Yes ☐No	Pacemaker	☐ Yes ☐No	Whooping cough	☐Yes ☐No
Fractures	☐Yes ☐No	Parkinson's disease	☐ Yes ☐ No	Other _____	_____
Glaucoma	☐Yes ☐No	Pinched nerve	☐ Yes ☐ No		

Exercise: none ☐ moderate ☐ daily ☐ heavy ☐ **Work activity:** sitting ☐ standing ☐ light labor ☐ heavy labor ☐

Habits: smoking (packs/day)___ alcohol(drinks/week)___ coffee/caffeine drinks (cups/day)___ High stress: why?_____

Are you pregnant? Yes ☐ No ☐ Due date_____

Injuries/Surgeries you have had (falls, head injuries, broken bones, dislocations, surgeries, etc.) *List Date(s) & Description:*_____

_____

Medications	**Allergies**	**Vitamins/Herbs/Minerals**
_____	_____	_____
_____	_____	_____

I understand that Green Health Acupuncture, Inc (GHA), and the staff will rely on my answers to the Intake Form, and affirm that my answers are true and complete. I agree to hold GHA, and the staff harmless for any injury which I may suffer as a result of my failure to fully complete the Intake Form truthfully and accurately.

Financial Policy: I understand that my insurance is an arrangement between myself and my insurance company, and not an arrangement between GHA and my insurance company. I also understand that if my insurance does not respond within 60 days, or if I suspend or terminate my schedule of care prescribed by GHA, that fees will be due and payable immediately. If I am a cash patient, I can pay on the date that the service is rendered by method of cash, check, or credit card (Visa, MasterCard). GHA does have the right to charge patients who cancel their appointments without giving a 24 hour notice, or who do not show up for their scheduled appointment.

Collections of Overdue Accounts: I agree to pay GHA interest on my outstanding account at the rate of 1.5% per month, beginning 60 days after services are provided to me. I further agree to pay all attorney fees, court costs, or other costs of collection if GHA incurs any such costs to collect money due on my account.

I have read and agree to all of the above conditions and allow you to speak to me at work or at home to discuss my account.

Patient Signature:_____ Date:_____