PATIENT INFORMATION (Please print) *Patient File #:* _____

Last Name: _____ First Name: _____ Middle Initial: _____

Birth Date: _____ (_____) Gender: M F Marital Status: M S D W other
MM-DD-YY Age

Mailing Address: _____
Street City State zip

Phone #: H ( ) _____ O ( ) _____ C ( ) _____

Email Address: _____ How you heard about us? _____
(Please specify the name of referral, internet or yellowbook if possible)

Emergency Contact: Name: _____ Relationship: _____ Phone #: _____

Patient SSN #: _____ DL#: _____ State: _____

Occupation: _____ Employer: _____

Employer address: _____
Street City State zip

PLEASE READ AND SIGN

I take full responsibility for any and all charges for services performed by Chung-Hwei Chernly, L.Ac., Dipl. Ac., OMD, regardless if I have insurance coverage or not. I realize full payment (or co-pay) for all services is due at the time the services are rendered. I have read and understand the office policy of the Acupuncture Center, Inc.

If I am or become an insurance patient, I authorize the release of any medical records necessary to process any insurance claims to process any auto accident claims or to give a progress report to any referring physician on my behalf. I authorize payment of medical benefits to Chung-Hwei Chernly/Acupuncture Center, Inc. for the services described on any processed insurance claims for recorded dates of service. I am personally aware of and responsible for the status of my insurance eligibility and benefits regardless of the source of those insurance benefits. If for any reason the insurance company does not pay for services performed, I assume full responsibility for all outstanding bills and will pay any balance due to Chung-Hwei Chernly/Acupuncture Center, Inc.

_____
Patient/Guardian name print Patient/Guardian signature Date

INSURANCE INFORMATION

Insurance Company: _____ Group/Plan # _____ Effective Date: _____

Insured's Name: _____ _____ Your relation to Insured: self spouse child other

Insured's Address if different from above: _____

Insured's ID/SS# _____ Insured's Birth Date: _____ Insured's Phone: _____

Insured's Gender: M F Insured's Employer: _____

Is this insurance: ( ) group plan ( ) TWCC ( ) auto ( ) other (explain) _____

If auto accident/ injury: Claim # _____ Date of injury _____

Secondary Insurance Company _____ ID/SS# _____

Secondary Insured's Name: _____ Date of Birth (MM-DD-YY) : _____

MEDICAL HISTORY Patient Name: _____

Height: _____ ft _____ in Weight: _____ lb

DO YOU HAVE OR HAVE YOU HAD ANY OF THE *FOLLOWING:* (Check only if it applies)

_____ abdominal pain	_____ common cold	_____ hernia	_____ prostate enlargement
_____ acid reflux	_____ constipation	_____ high blood pressure	_____ rheumatoid arthritis
_____ alcoholism	_____ depression	_____ hip pain	_____ sciatica
_____ allergies (air born)	_____ diabetes	_____ hyperthyroidism	_____ sclerosis, _____
_____ anemia	_____ disc disorder, cervical	_____ hypoglycemia	_____ seizures /convulsions
_____ arm pain	_____ disc disorder, thoracic	_____ hypothyroidism	_____ shoulder pain
_____ arthritis	_____ disc disorder, lumbar	_____ incontinence	_____ sleeplessness
_____ asthma	_____ earache/ear infection	_____ infertility	_____ skin infection
_____ back pain	_____ edema	_____ joint pain	_____ spondylosis
_____ back pain, lower	_____ elbow pain	_____ knee pain	_____ stenosis
_____ bronchitis	_____ emphysema	_____ leg pain	_____ tendonitis
_____ bursitis	_____ endometriosis	_____ menstrual irregularity	_____ tinnitus
_____ candidiosis	_____ fatigue, chronic	_____ menstrual pain	_____ TMJ
_____ carcinoma/cancer	_____ fibromyalgia	_____ migraines	_____ tingling, numbness, _____
_____ carpal tunnel syndrome	_____ flu	_____ neck pain	_____ trigeminal neuralgia
_____ chest pain	_____ foot pain	_____ neuroma	_____ twitch, tremors
_____ cholesterol, high	_____ hand pain	_____ osteoarthritis	_____ vertigo
_____ circulation problems	_____ headaches	_____ osteoporosis	_____ others _____
_____ colitis / diarrhea	_____ hepatitis,	_____ pneumonia	

Currently Medication &/or Herbs: _____

Previous surgeries (& dates): _____

Have you ever been tested positive for AIDS? Yes No HIV? Yes No Hepatitis C? Yes No

WOMEN ONLY: Last menstrual period: _____

Currently pregnant: Yes No If yes, how long? _____ Ever pregnant: Yes No Number of live births: _____

NOTICE TO THE PATIENT

I am seeking treatment at the Acupuncture Center for the following condition: _____

_____

Pursuant to the requirements of title 3, sec. 205.301(a)(1) of TX. OCC code governing the practice of acupuncture.

I, _____, am notifying the acupuncturist(s), C. H. Chernly, and/or H. L. Chung, of the following:

Last Visit Date to PCP: _____ Name of PCP: _____ Referred by PCP? Y N

Currently under another physician's care? Yes No If yes, for: _____

I have been evaluated by a physician (MD/DO) or dentist for the condition being treated within 6 months before receiving acupuncture treatment. Initial of Patient _____ Date: _____

(If no initial above, patient must sign below attesting that the Acupuncturist has referred him/her to a physician as pursuant to the requirement of sec. 205.301(b), title 3, TX OCC code governing the practice of acupuncture.) I recognize that I should be evaluated by a physician (MD/DO) or dentist for the condition being treated by the acupuncturist. This serves as a referral by the acupuncturist for me to see a physician. It is my responsibility and choice whether to follow his or her advice.

Patient's signature _____ Date _____

_____

Pursuant to the requirements of title 3, sec. 205.301(a)(2)(c) of TX OCC code governing the practice of acupuncture:

I have received a referral from my CHIROPRACTOR within the last 30 days for acupuncture? Yes No

After being referred by a chiropractor, if after 30 days or 20 treatments, whichever comes first, no substantial improvement occurs in the condition being treated, I understand that the acupuncturist is required to refer me to a physician, and consider this written notice a referral in advance. It is my responsibility and choice whether to follow this advice.

Patient's signature _____ Date _____