



NEW PATIENT INTAKE

Please fill out completely

Today's date:			Your PCP:		
PATIENT INFORMATION					
Last name:		First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms. <input type="checkbox"/> Dr. <input type="checkbox"/> Ph.D <input type="checkbox"/> MA/MS <input type="checkbox"/> BA/BS <u>Relationship Status (circle one):</u> Single - Dom. Partners - Married - Separated - Divorced - Widowed	
# of Children:	Current Ages:	Date of Birth:	Place of Your Birth:	Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Street address:			Phone #:	2ndry phone #:	
City:		State:	Zip:	Email:	
Occupation:		Weekly Hours:	Job Satisfaction Level:		
Whom may we thank for your referral?		<input type="checkbox"/> Friend:	<input type="checkbox"/> Insurance Plan:	<input type="checkbox"/> Hospital:	
<input type="checkbox"/> Dr.	<input type="checkbox"/> Family Member:	<input type="checkbox"/> Internet Site:	<input type="checkbox"/> Yellow Pages	<input type="checkbox"/> Other:	
Other family members seen here:					
HEALTH CARE INFORMATION					
Purpose(s) of Your Visit:			Additional Comments:		
1. _____					
2. _____					
3. _____					
4. _____					
5. _____					

Previous Experience with Acupuncture? <input type="checkbox"/> Yes <input type="checkbox"/> No With Whom: Results:	What other health care providers are you working with? Physician: _____ D.C.: _____ Massage Therapist: _____ Nutritionist: _____ Psychotherapist: _____ Other: _____	Currently <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Past <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Seeking One <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
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INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Insurance Provider:	Your Plan I.D. #:	Group #:
Subscriber's name:	Subscriber's I.D. #:	Date of Birth:
Patient's relationship to subscriber:	<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other	

For Office Use:

Plan Effective Date	Deductable:	Amount Met	Deductable Waiver:
Name, Date & Time:	Acupuncture Benefits:	Additional Notes:	

IN CASE OF EMERGENCY

Name:	Relationship to patient:	Home phone no.:	Work phone no.:
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The above information is true to the best of my knowledge.

For Insurance Patients:

I authorize my insurance benefits be paid directly to the physician. I also authorize the medical office of Jeffrey Szilagyi L.Ac. and/or insurance company to release any information required to process my claims.

For Prompt Pay Patients:

I understand that I am financially responsible for services rendered at the time of service.

Patient/Guardian signature

Date