***Patient Registration***

Please take a moment to complete the attached questionnaire.

**Patient’s Name** :

**Street Address**:

**City/State/Zip**:  **Best Phone Number**:

**E-mail Address**:

|  |  |  |
| --- | --- | --- |
| **May we add you to our email list?** |  |  |

**Date of Birth: Age: Birth Place:**

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**Name(s) & relationship of people in your household:**

**In case of emergency, contact (name and phone number)**

**Hospitalizations and surgeries prior to service (Include event dates by month and year):**

**Insurance Company: Phone Number**:

**Group Number**: **ID Number**:

|  |  |  |
| --- | --- | --- |
| **Responsible Party:**  |  |  |

**Name (if not Self)**: **Relationship**: **Date of Birth**:

|  |  |  |
| --- | --- | --- |
| **Is this work rela)ed ?** |  |  |
| **Is Workmen’s Compensation involved?** |  |  |
| **Is this auto accident related ?** |  |  |

**What concerns would you like to address in your acupuncture treatments? And how long have you had the condition(s)?**

**I authorize Stephanie M Brown to use my personal health information for healthcare operations.**

**Patient Signature Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
(or responsible party)**