Family Wellness Acupuncture Inc.

CONFIDENTIAL PATIENT INFORMATION

Date	**Full Name**			**Preferred Name/Nickname**	
Gender **M F**	**Date of Birth** (MM/DD/YYYY)	**Age**	**Marital Status**		
Address		**City**		**State**	**Zip**
Social Security Number			**Driver's License Number**		
Daytime Phone # (home, work, cell – circle one) **( )**			**Alternate Phone #** (home, work, cell – circle one) **( )**		
Email (Your email will be used to send appointment confirmations, birthday cards or newsletters.)					
Occupation			**Employer**		
Emergency Contact			**Relationship**		
Phone Number of Emergency Contact **( )**			**Preferred Method of Contact** **Email Phone Text Msg Postal Mail**		

Primary Insurance	**Alternate Insurance**
Subscriber Name	**Subscriber Name**
Group Number	**Group Number**
ID Number	**ID Number**
Date of Birth (MM/DD/YYYY)	**Date of Birth (MM/DD/YYYY)**
Patient's Relationship to Subscriber **Self Spouse Child**	**Patient's Relationship to Subscriber** **Self Spouse Child**

Family Wellness Acupuncture Inc.

Primary Care Doctor	Specialty
How did you hear about us?	
Cancellation Policy – I acknowledge that I will give <u>at least 24 hours</u>' notice of cancellation to avoid a charge for the session. This is a courtesy to other patients who may need that appointment time. INITIALS _____	