Gao Acupuncture
Patient Information Sheet

CONFIDENTIAL

Patient Information

Last Name: ______________________ First Name: ______________________

Address: ______________________ City: ______________ State: ________

Home Phone: ______________________ Work Phone: ______________________

Cell Phone: ______________________ Fax: ______________________

Email: ____

Do you want to receive email notifications before appointments? ☐Yes ☐No

Birth Date (MM/DD/YY): ______________ Sex: ☐Male ☐Female

Height: __________ Weight: __________

Occupation: ____

Employment status (Check all that apply):
☐ Full-time ☐ Part-time ☐ Self-employed ☐ Retired ☐Unemployed ☐ Student

Marital Status:
☐ Married ☐ Domestic Partner ☐ Single ☐ Divorced ☐ Other: ______________

Emergency Contact: ______________________ Relationship: ______________

Phone: ______________________

How did you hear about Gao Acupuncture?

____

Major Concern

What is your major concern?

____

Other Concerns: ____

How long have you had this condition? ______________________________

Have you had this or similar condition in the past? ______________________

What activities aggravate your condition? ______________________________

What medications are you taking? (if any) ______________________________

Non-prescription drugs? ____

Primary Care Physician Information

Primary Physician: ____________________________ Phone Number: ____
Physician's Address (or name of clinic/hospital):

____

Insurance Information (if applicable)

Insurance Company: ______________________________ Policy Holder Name:________________________________

Birth Date (MM/DD/YY): _______________ Relationship to Patient: ____

Insurace Company Address: ____ Telephone: ________________________

Policy Number / ID number : ____

Group Number: ____

Confidentiality: *Your Patient records and Information will be kept strictly confidential and will only be shared when necessary to provide your care, or under your written authorization, or when required by law.*

Signature ____ Date ________________