ARTUPUNCTURE WELLNESS CLINIC
PATIENT REGISTRATION FORM

PLEASE PRINT	PLEASE COMPLETE ALL INFORMATION	PLEASE PRINT

PATIENT – This section refers to patient only **TODAY'S DATE:**________/________/________

LAST NAME FIRST MI	SEX M F	AGE	BIRTH DATE	MARITAL STATUS (X ONE) ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed
MAILING ADDRESS	SOCIAL SECURITY #			
CITY STATE ZIP CODE	EMPLOYER			OCCUPATION
EMAIL ADDRESS	EMPLOYER ADDRESS			WORK PHONE ( )
HOME PHONE ( ) CELL PHONE ( )	CITY		STATE	ZIP CODE

INSURANCE (PRESENT ID CARDS FOR PHOTO COPYING)

PRIMARY INSURANCE____	SECONDARY INSURANCE_____________________________________
POLICY # ____	POLICY # ____
GROUP____________________EFFECTIVE DATE__________________	GROUP____________________EFFECTIVE DATE__________________
POLICY OWNER NAME____	POLICY OWNER NAME____
POLICY OWNER SS#_____________________D.O.B.________________	POLICY OWNER SS#_____________________D.O.B.________________

PAYMET FOR SERVICES:
I clearly understand and agree that all services rendered to me charged directly to me and I am responsible for the payment. Arthur Gazaryants may, as a courtesy bill my insurance for his services, in that case I agree to bring all the checks issued for those services directly to Arthur Gazaryants or his staff, or write them a check of equal value. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me or my dependent will be immediately due and payable.

Initials:_____________________________

INFORMED CONSENT:
I hereby request and consent to the performance of acupuncture, herbal/nutritional therapy and other therapeutic procedures and modalities, including, but not limited to various modes of physical therapy and diagnostic procedures included but not limited to blood tests, saliva tests and x-rays, on me by Arthur Gazaryants, L.Ac., and/or any other licensed physician who may treat me while employed by, working for or associated with or serving as backup for Arthur Gazaryants, L.Ac. I have had the opportunity to discuss with Arthur Gazaryants the nature and purpose of Acupuncture treatments and other procedures and modalities. I understand that progress in my treatment, may vary according to my condition. I understand and am informed that, in the practice of acupuncture there are some risks to treatment. I do not expect Arthur Gazaryants, L.Ac. to be able to anticipate and explain all risks and complications, and I wish to rely on him to exercise judgment during the course of the treatment, which he feels at the time, based upon then known, is in my best interests.

Initials:_____________________________

IN CASE OF EMERGENCY NOTIFY: NAME (COMPLETE)	RELATIONSHIP	WORK PHONE	HOME PHONE

WHO MAY WE THANK FOR REFERRING YOU TO ARTUPUNCTURE:

PRIMARY CARE PHYSICIAN: PHONE:

DO WE HAVE YOUR PERMISSION TO LEAVE MESSAGES ON YOUR VOICE MAIL REGARDING PERSONAL MEDICAL INFORMATION?

(CHECK ONE) ☐ YES ☐ NO

IF YES, AT WHICH PHONE NUMBER MAY WE LEAVE A PERSONAL MESSAGE (CHECK ONE OR BOTH) ☐ HOME ☐ CELL