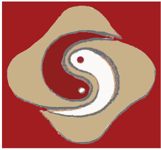

Chinese Acupuncture & Natural Therapy Center

2425 N. Milwaukee St., Boise, Idaho 83704 (208) 373-5888

New Patient Form (please print)

Thank you for taking the time to fill out this form thoroughly. It will help us serve you better.

Personal information

Last name ______________________ First name ______________________ Middle name ______

Address (street) ____

City ______________________ State ____________ Zip code ____________

Home phone (   ) ______________________ Work phone (   ) ______________________

E-mail ____

Emergency contact name ______________________ Phone (   ) ______________

Date of birth (month-day-year) ______________ Social security number ______________

Age ________ Sex (circle): male   female   How many children? ______________

Marriage status (circle): single   married   widowed   divorced   life-partner

Primary physician ____

Employed by ______________________ Occupation ______________

Employer address ____

Insurance Co. ______________________ Plan/Group ______________

Policy ID# ______________ Co-pay $ __________ Deductible $ __________

Maximum times or amount of office visits for Acupuncture ______________________

Who may we thank for referring? (name) ______________________

(or circle)   newspaper ad   Qwest/Dex ad   Boise Impact ad   Yellow book ad

Other/more referral information ____

Please continue to fill out health and medical information on page 2. >>

Informed consent to Acupuncture & Chinese Medical Treatment

Idaho law requires that each patient be informed regarding the scope of practice in which a licensed acupuncturist is allowed to engage. Shiyan Zhang, Ying Wang L.Ac.'s clinical practice includes: use of acupuncture needles and electric stimulus to stimulate acupuncture points and meridians; acupressure; dermal friction technique; infrared heat treatment; cupping; Chinese herbs and dietary advise based on Traditional Chinese Medicine.

Side effects may occur in a small percentage of patients and may include the following: some pain following treatment in the treated area, minor bruising or bleeding, infection, needle sickness (fainting), and broken needle. For cupping technique, after cupping there is a blood stasis or bruise at the local area. General it will disappear several days later.

If you have severe bleeding disorder or have a pacemaker or you are pregnant, please let Shiyan Zhang, Ying Wang L.Ac. know prior to treatment.

Confidential policy

Shiyan Zhang, Ying Wang L.Ac. keep a record of the health care services that she provides to you. They will not disclose your records to others unless you direct them to do so, or the law authorizes, or compels them to do so.

Financial policy

Health and accident insurance policies are an arrangement between an insurance carrier and yourself. Shiyan Zhang, Ying Wang L.Ac. will prepare necessary reports and forms to assist you in receiving the coverage by your insurance company for the treatment. Any co-payment required by your insurance company or payment for non-insured patient is expected at the time of the visit.

Please read additional information on page 2. >>

Health related information

Please list the main problems you are having or reason for this appointment ____________________

____

____

Have you seen other health care providers for this? (If yes, please list diagnosis and treatments.) __________

____

____

Family history

Mother: (circle) living deceased Age, if alive ____________________

Reason for death, if deceased ____________________

Any pronounced illnesses ____________________

Father: (circle) living deceased Age, if alive ____________________

Reason for death, if deceased ____________________

Any pronounced illnesses ____________________

Siblings: how many? ____________________

Diseases found in blood relatives: (circle) diabetes cancer asthma depression high blood pressure alcoholism heart disease osteoporosis mental health problems

Other ____________________

Medical history

Serious illnesses ____________________

Surgery ____________________

Major accidents ____________________

Current medications ____________________

Current supplements/herbs ____________________

Others ____________________

Allergies (medication, food, environment) ____________________

Habits (coffee, tobacco, alcohol, drugs) ____________________

Special diet or exercises ____________________

HIV positive? (circle) yes no

Any other problems you would like to discuss? ____________________

I read the above information and agree that I am well informed regarding the treatment provided by Shiyan Zhang, Ying Wang L.Ac. and had an opportunity to ask questions about them. I also understand that I am responsible to pay all services rendered to me that my insurance carrier does not cover. **By signing below, I agree to receive the treatments. I understand that my consent covers the entire course of treatment for my present condition and for any future conditions for which I seek treatment from Shiyan Zhang, Ying Wang L.Ac.**

Patient signature ____________________ Date ____________________

Parent or guardian signature ____________________