Chinese Acupuncture & Natural Therapy Center

2425 N. Milwaukee St., Boise ID 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) online search 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

Please initial to indicate you've read 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

Please initial to indicate you've read 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 _____