Integrated Center for Oriental Medicine

New Patient Preliminary Information Questionnaire

Patient: ____
(first) (m.i.) (last)

Address: ____

City: ____________________ State: __________ Zip code: ______________

Phone: ____________ ______________ ______________
(cell) (home) (work)

E-mail: ______________________

Occupation: ____________________ Date of Birth: ______________

Circle one: Single Married Divorced Widowed Spouse's name:______________

Female: Are you pregnant? ______ Number & Ages of children: ______________

Emergency Contact: ____________________ Relation: ______________

Emergency Contact's Phone: ______________

Date of Accident/Beginning of Illness: _________ Location of Accident: __________

Have you lost time from work? _______ Dates: ______________________

How did it occur? (circle one) Auto Collision On-the-Job Other: ______________

How did you hear about us? ______________________________

All professional services rendered are charged to the patient and remain the patient's responsibility regardless of insurance coverage. Payment is due at the time services are rendered unless arrangements have been made in advance.

Please give cancellation notices 24 hours in advance to your scheduled appointment or a $35.00 fee for a missed appointment will be charged. Please initial here stating that you have read and understood this policy: _____________

Insurance Authorization (Please read and sign)
I hereby authorize the Integrated Center for Oriental Medicine to release all medical information required by my insurance company so that I may file for medical benefits. *I also state that the above information is correct to the best of my knowledge.*

______________________________ ______________
(Signature) (Date)