

Oriental Medicine Specialists, P.C.

New Patient Information

Date:

Full Name:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Social Security Number:	
Address:	
City:	State: Zip:
Billing/Mailing Address:	
City:	State: Zip:
*Please indicate if you want in all correspondence from this office sent in a sealed envelope marked "CONFIDENTIAL." <input type="checkbox"/> YES <input type="checkbox"/> NO	
Home Phone:	Work Phone:
<ul style="list-style-type: none"> • Phone number where you want to receive calls about your appointments and/or health care information if other than your home number: • Can confidential messages be left on your answering machine or voicemail <input type="checkbox"/> YES <input type="checkbox"/> NO 	
Email Address:	
Date of Birth:	Age: Place of Birth:
Marital Status:	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Co-habiting
Years Married (present Marriage)	(previous Marriage)
Education (Highest Level Attained)	
Occupation:	How Long: years

RELEASE OF INFORMATION & EMERGENCY CONTACT INFORMATION

Family members or other persons we may inform about medical condition(s), including treatment, payment and health care.			
Name:	Ph.		
Address:	City:	State:	Zip:
Name:	Ph.		
Address:	City:	State:	Zip:
Emergency Contact:	Ph.		

PHYSICIAN & REFERRAL INFORMATION

Please list any Physician or Health Professional you currently under the care of?
Referred by:

Payment and Cancellation Agreement:

I understand that payment is expected at the time of my visit and agree to make full payment at the time of my visit. I understand that when I schedule an appointment for myself that I am agreeing to pay for that set aside time as well as any treatment I receive during that time. I agree to provide this office with at least 24 hours notice when canceling an appointment. **I understand that if I cancel an appointment without giving 24 hours notice I will be required to pay the cost of the appointment for the time I reserved.**

Patient Signature: _____ Date: _____

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MAJOR COMPLAINT

What is your primary reason for this visit?

FAMILY HISTORY

Father	<input type="checkbox"/> Alive	<input type="checkbox"/> Deceased		
Present Health or Cause of Death:				
Mother	<input type="checkbox"/> Alive	<input type="checkbox"/> Deceased		
Present Health or Cause of Death:				
Brothers	# Alive	Current Health	#Deceased	Cause of Death
Sisters	# Alive	Current Health	#Deceased	Cause of Death
Children	#Alive	Current Health	#Deceased	Cause of Death

Check any illnesses that have occurred in any **blood relatives**:

<input type="checkbox"/> Diabetes <input type="checkbox"/> Cancer <input type="checkbox"/> Bleeding tendency <input type="checkbox"/> Kidney disease <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Obesity <input type="checkbox"/> Heart disease <input type="checkbox"/> High blood pressure <input type="checkbox"/> Nervous illness <input type="checkbox"/> Allergy <input type="checkbox"/> Alcoholism <input type="checkbox"/> Mental illness <input type="checkbox"/> Stroke <input type="checkbox"/> Other:

PERSONAL MEDICAL HISTORY

How would you describe your health as a child?

Check any illnesses or conditions **you** have or had in the past:

<input type="checkbox"/> Diabetes <input type="checkbox"/> Glaucoma <input type="checkbox"/> Heart trouble <input type="checkbox"/> High blood pressure <input type="checkbox"/> Syphilis <input type="checkbox"/> Vein trouble <input type="checkbox"/> Cancer <input type="checkbox"/> Asthma <input type="checkbox"/> Jaundice <input type="checkbox"/> Gonorrhoea <input type="checkbox"/> Bleeding tendencies <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Mumps <input type="checkbox"/> Pneumonia <input type="checkbox"/> Allergies <input type="checkbox"/> Kidney disease <input type="checkbox"/> Rheumatic fever <input type="checkbox"/> Nervous disorder <input type="checkbox"/> Measles <input type="checkbox"/> Chicken pox <input type="checkbox"/> Meningitis <input type="checkbox"/> HIV <input type="checkbox"/> Multiple sclerosis <input type="checkbox"/> Mononucleosis <input type="checkbox"/> High fevers <input type="checkbox"/> Antibiotic uses <input type="checkbox"/> Hepatitis <input type="checkbox"/> Polio <input type="checkbox"/> Depression <input type="checkbox"/> Other

List illnesses requiring operation or for which you were hospitalized (in and out patient services) including the date and doctor:

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Recommendation for Examination by a Physician

I, R. Keith Bell, L.Ac. (VA Lic. # 0121000121), recommend to you,

_____ that you be examined by a Physician regarding the condition for which you are seeking acupuncture treatment.

I understand this recommendation.

Patient Signature

Date

Virginia law requires that I give this form to you if I do not have written evidence that you have received a diagnostic exam in the last six months from a licensed practitioner of medicine, osteopathy, chiropractic or podiatry regarding the condition for which you are seeking treatment. (*Code of Virginia §54.1-2956.9, 18 VAC 85-110-10*).

Acupuncturist Signature

Date

Patient Consent

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice
- The Practice reserves the right to change the Notice of Privacy Policies
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease
- The Practice may condition treatment upon the execution of this Consent.

Printed Name – Patient

Printed name - Practice representative

Patient Signature

Practice representative signature

Date: / /

Date: / /