NEW LEAF ACUPUNCTURE ••• Cheryl Kalsch-Lowrance LAc ••• 343 SE 3rd Ave, Hillsboro OR ••• 503-352-0909

New Patient information

Name:_____ Date:_____

Birthdate: _____ Age: _____ M F Marital Status:_____

Phone: (home)_____ (cell)_____(work)_____

CIRCLE the best number for calling during the day. **UNDERLINE** any number we may use to leave a message

Address:_____

City/State/Zip: _____ Email: _____

Occupation: _____ Employer: _____

Physician: _____ Phone: _____

Emergency contact:_____

Phone#/relationship:_____

How did you find out about us? _____

MEDICAL ALERTS

Medicine/Supplements_____ Allergies_____ Other_____

Financial Responsibility

Patients are ultimately responsible for payment for services received. If paying by insurance, please be sure to check with your insurance company to verify your acupuncture coverage and benefit limits.

I agree to pay for services or goods received that are not paid by insurance. We do require a 24 hour notice for cancellations. I understand that I may also be charged for missed appointments.

Signature: _____

Insurance Information

(If we photocopy insurance card, you need not write duplicated info.)

Primary Insurance:_____ ID/group #_____

Secondary Insurance:_____ ID/group#_____

Copay? Y N Amount:_____ Annual benefit limit to acupuncture:_____

Is your insurance through yourself or someone else?

If it is someone else, please give the name, relationship, and address/phone if different:

_____