Alpenglow Acupuncture, LLC

New Patient Intake Information Form

PATIENT:____DOB:____________Age:________
Last Name First Name Initial

Please Circle how you wish to be contacted. **Can we leave you a voice mail message? YES NO**
Can we text your reminder appointment info? YES NO

Home Phone:________________Cell Phone:__________________Work Phone:________________

Mailing Address:___________________________City:______________State:________Zip:__________

Street Address:________________________________City______________State:________Zip:________

E-Mail Address:____________________________________Social Security #______________________

Occupation:____

Employer: ____

Sex: M F Marital Status: Single Married Partner Widow/er Separated Divorced

Responsible Party: ____________________________DOB:____________SS#__________________

Home Phone:________________Cell Phone:______________Address:___________________________

Is this related to a Work Comp claim? **Yes** **No** -or- Motor Vehicle Accident? **Y**es **N**o

Primary Insurance:____

Subscriber Name:______________________________DOB:____________SS#__________________

Subscriber ID #:____________________________________Group #:_________________________

Secondary Insurance:____

Subscriber Name:______________________________DOB:____________SS#__________________

Subscriber ID #:____________________________________Group #:_________________________

Emergency Contact:_____________________________________Relationship:_______________

Phone:____

Referred By: Friend/Co-worker/Relative __________Health Care Provider_____________Internet__________

Release, Assignment and Statement of Responsibility	**Notice of Privacy Practices**
I authorize release of any information necessary to process my insurance claims and assign and request payment directly to the provider(s). I understand that I may revoke this consent at any time, in writing, to this office. I further understand that I am responsible for payment for all products and services rendered to me or any patient for which I am the guarantor of payment.	**Acknowledgement of Receipt of Notice of Privacy Practices** I, ____________________________, acknowledge and agree that I have reviewed a copy of Alpenglow Acupuncture's Notice of Privacy Practices made available to me. I acknowledge that I may request a copy of the notice at any time.
X Date	X Date

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Traditional Medicine for Modern Times