



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? **Yes No**

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

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.

X _____ Date

Notice of Privacy Practices

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

2017/12/20