Patient Information Form

/ /
Date

Last Name | First Name | Middle Initial

Legal Guardian

( )
Home Address | City, State and Zip | Home Phone

( )
Mailing Address if different from Home | Work Phone

/ /
Date of Birth | _____ Married _____ Single _____ Divorced _____ Widowed | Name of Significant Other

( )
Who should we contact in case of emergency? | Contact Number

How were you referred to Downeast Acupuncture?

About Your Condition:

/ /
Is the condition due to illness or accident? | Approximate date condition began?

Did your Accident occur while at work?____ If yes, please complete Work Injury Information

Were you involved in an auto accident?____ If yes, please ask for the Personal Injury Form

Insurance Information

Medicare? Yes___ No ___ Medicare ID# _____

Name of Group or Private Health Insurance | Policy or Group # | ID #

( )
Address | Phone

Secondary Insurance Co or Medi-Gap | Policy or Group # | ID#

( )
Address | Phone

Work Injury Information

Name of Employer

( )
Address | Phone

Date of Accident | Approximate Time of Accident | Accident Reported to Employer?

Describe the accident or injury