Liz Newman, AP

NEW PATIENT INFORMATION

1. Name _____
   First Middle Last
2. Address _____
   Street City State Zip
3. Cell Phone _____ 4. Other Phone _____
5. Fax _____ 6. Email _____
7. Age _____ 8. Date of birth ____ 9. Sex _____ 10. Marital: M S D W

11. Appt Reminders/Msg ☐ Home ☐ Work ☐ Cell ☐ E-mail

NOTE: for your privacy please note if you DO NOT want a message left on your voice mail about your appointment or about your visit.

CASE HISTORY

12. Chief Complaint _____
13. Complaint result of: ☐ Auto Accident ☐ Injury ☐ Job Related ☐ Other
14. Date of accident/Injury/Other ____/____/____
15. Have you seen any other doctor about this condition? _____ If yes, when? _____
    Doctor's Name _____ Address _____
16. Have you had recent X-Rays? _____ If yes, when? _____ Area X-Rayed _____
17. **Primary Care Physician** _____ **Phone:** _____
18. **Emergency contact**
    Name Street City Phone

FOR FEMALES: Are you pregnant? _____ IF YES, HOW LONG? _____

FOR MINORS: List both parents' names and addresses

_____

_____

INSURANCE INFORMATION

If you have insurance and believe it covers acupuncture - please fill out the attached Insurance Verification form.

NOTE: if you did not fill this out prior to your first visit, you will be required to pay for your first visit out of pocket until verification has been established. If you are covered I will refund your initial payment after full verification.

DATED _____ PATIENT'S SIGNATURE _____
(Parent's signature if patient is minor)