MayStar Natural HealthCare Center

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San Jose, CA95128 Fax: (408)899-6230

PATIENT REGISTRATION AND MEDICAL HISTORY

Name: Last: First:	Date:
Address: City: State: Zip:	
Phone: [home] [cell] Email:	
Preferred contact phone for appointment messages:	
Birth Date: Age: Birth Place:	
SS#: Height: Weight:	
Status: [ ] single [ ] in relationship [ ] married [ ] divorced [ ]widowed	
Spouse Name: Last: First:	Spouse Birthdate:
No. of children Employer/School: Occupation:	
How did you find out about us?	Referred By:
Emergency contact: Contact telephone # Relationship to you	

HEALTHCARE & INSURANCE

Primary Physician's Name:	
Address:	
Date of Last Visit:	
Primary Insurance Type:	Telephone #: ( )
Billing address:	
Policy Holder's Name:	
Policy # Group # Member ID#	
May we communicate directly with your primary physician that we are treating you? [ ] Yes [ ] No	
Work's Comp.: [ ] Yes [ ] No Auto Accident: [ ] Yes [ ] No Other:	

HAVE YOU EVER HAD ACUPUNCTURE? [ ] Yes [ ] No For what reason?___________________________

MAJOR SURGERIES, HOSPITIAZATIONS, X-RAYS, MRI'S…

(If you have ever been hospitalized for any serious medical illness, procedures or surgical operations)

Date	Operation, Procedure or Illness	Name of Hospital

LIST ALL MEDICATION YOU ARE CURRENTLY TAKING

Medication	For what condition	Dosage

DO YOU EXPERIENCE THE FOLLOWING SYMPTOMS PRESENTLY OR FREQUENTLY? (PLEASE CHECK)

[ ] Cramps in limbs
[ ] Numbness in limbs
[ ] Seizures
[ ] Varicose Veins
[ ] Arthritis
[ ] Paralysis
[ ] Rheumatic Fever
[ ] High Blood Pressure
[ ] Heart Disease
[ ] Liver Disease
[ ] Kidney Disease
[ ] Asthma
[ ] Blood Disease
[ ] Insomnia
[ ] Diabetes Mellitus
[ ] Hepatitis
[ ] Eye Disease
[ ] Ear Disease
[ ] Tuberculosis
[ ] HIV
[ ] Cancer

FAMILY MEDICAL HISTORY: Do your close relatives have

[ ] High Cholesterol
[ ] Hypertension
[ ] Hypotension
[ ] Heart Disease
[ ] Stroke
[ ] Diabetes
[ ] Kidney Disease
[ ] Mental Disorder
[ ] Chronic Hepatitis
[ ] Cancer
[ ] Asthma
[ ] Other:

FEMALES ONLY:

Pregnant? ☐ Yes ☐ No **Menses:** Length of Cycle _______________ Days.

Flow: Light / Heavy / Normal **Duration**: _______________ Days

PERSONAL HABITS

[ ] Smoking [ ] Alcohol

PLEASE LIST YOUR TOP 3 HEALTH CONCERNS THAT HAVE BROUGHT YOU HERE IN ORDER OF IMPORTANCE

Condition **Past Treatment(s) and Results**

1. ______________ ____

How does this condition affect you? ____

2. ______________ ____

How does this condition affect you?

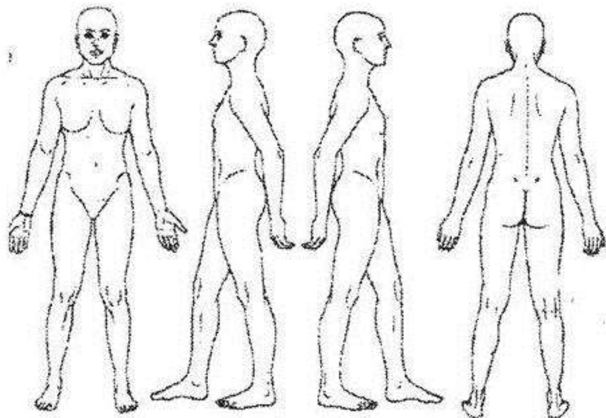
____

3. _______________ ____

How does this condition affect you?

____

Circle areas of concern



Pain 1 2 3 4 5 6 7 8 9 10

Do you take Multi-vitamin? ☐ Yes ☐ No What brand? ___________________

Is it ☐ Synthetic (made from chemicals) ☐ From Whole Foods ☐ Not Sure

Are you Vegetarian? ☐ Yes ☐ No

Are you interested in the following?

- □ Weight Loss
- □ Stress Reduction Workshops
- □ Detoxification
- □ Yoga
- □ Meditation
- □ Tai Chi
- □ Health information by email from MayStar Natural HealthCare Center

- I certify that, to the best of my knowledge, the information I have provided herein are accurate and correct.

- My signature authorizes **Sarah S Liu, L.Ac.** to treat me (or the patient who I am legally responsible) with acupuncture, Chinese medicinal herbs and massage within the licensure granted by the Medical Quality Assurance Board of the State of California and the California Acupuncture Committee.

- I authorize release of any medical or other information necessary for insurance claim processing and I understand that my individually identifiable medical information will be used only as necessary for purposes of treatment, payment and or other healthcare operations.

- **Financial Terms:** The fees for office services are payable at the time of each visit. For your convenience, we accept cash, credit card and personal checks with driver's license for identification. If you carry health insurance covering any services that we offer, you should provide us with a proper identification card showing proof of coverage on your first visit. Remember, the fee for treatment is obligation that you have with us. Should there be a dispute between you and your insurance company, and your insurance company refuse to make payments to us, you will become directly liable for payment of the medical bill.

- **Insurance Policy:** I also understand that I am responsible for paying all acupuncture treatment costs that **are not covered by my insurance provider.** Within 30 days of the date on an invoice for acupuncture services, I will submit the balance due. I acknowledge and accept that any past due balance will result in a **penalty fee equal to 1.5% of the past due** balance each month.

Signature____Date________________

(Patient, Parent or Guardian)