PATIENT INFORMATION FORM

Middle Path Acupuncture & Oriental Medicine

* Denotes a required field!

Patient Information

* **Patient Name:**_____

* **Patient Address:**_____

Address City State Zip

* **Home Phone:**_____ * **Sex**: Male ❑ Female ❑

* **Student:** Full-time ◯ Part-time ◯ No ◯ School: _____

* **Marital Status:** Single ◯ Married ◯ Divorced ◯ Widowed ◯ Other_____

* **Work**: Full-time ◯ Part-Time ◯ Retired ◯ Self-Employed ◯ Unemployed ◯

* **Patient Employer:**_____

* Work Address:_____

(Address) (City) (State) (Zip)

Work Phone:_____

* **Social Security #:**_____

* **Date of Birth:**_____ * **Relationship to Insured:** _____

Insured Information (if patient not policy holder)

* **Insured Name:**_____

* **Insured Address:**_____

(Address) (City) (State) (Zip)

* **Home Phone**:_____ * **Sex**: M F

* **Student:** Full-time ◯ Part-time ◯ No ◯ School: _____

* **Marital Status:** Single ◯ Married ◯ Divorced ◯ Widowed ◯ Other_____

* **Work**: Full-time ◯ Part-Time ◯ Retired ◯ Self-Employed ◯ Unemployed ◯

* **Employer:**_____

* Work Address:_____

(Address) (City) (State) (Zip)

Work Phone:_____

* **Social Security #:**_____ * **Date of Birth:**_____

Referring Physician

* **Physician's Name**:_____

* Address:_____

(Address) (City) (State) (Zip)

* **Phone:**_____ * **Referral Number:** _____

Other Referral Source (*Name*): _____ Phone: _____

Primary Insurance Information

* **Company Name:**_____

* Address:_____

(Address) (City) (State) (Zip)

Contact Name:_____ * **Phone:** _____

* **ID Number:**_____ * **Group Number:** _____

* **Date of Accident/Injury/Illness**:_____ * **Policy Holder :** Self ◉ Parent ○ Spouse ○ Other ○

* *Authorization*

- I hereby authorize the release of any medical or other information necessary to process this claim.
- I also request payment of government benefits either to myself or to the party who accepts assignment.
- I hereby authorize payment of medical benefits to Jeff Lippincott, LAc for services rendered. I also understand I am financially responsible for any balance not covered by my insurance carrier.

* **Signed**: _____

* **Date:** _____

Please attach a copy of the Patient's Insurance Card (front and back) to this form!