Virginia Wagenknecht L. Ac.

PATIENT CONFIDENTIAL INFORMATION

Name: _____
FIRST MIDDLE LAST

Address: _____
STREET CITY, STATE ZIP

Home Phone:_____ Cell Phone:_____
DOB: _____ Sex: _____ Marital : M S D W
Social Security #: _____ DL #: _____
Occupation: _____ Employer: _____
Employer's Address: _____
Business Phone: _____ E-mail: _____

EMERGENCY CONTACT

In case of emergency call:
Name: _____ Phone Number _____
Alternative Phone Number _____ Relationship: _____

Name: _____ Phone Number _____
Alternative Phone Number _____ Relationship: _____

CASE HISTORY

Chief Complaint: _____
Complaint result of: Auto Accident ___ Injury ___ Job Related ___ Other ___
Have you seen any other Doctor about this condition:_____ Date: _____
Name of Doctor: _____ Phone: _____
Please list any diagnostic methods (X-Ray / MRI / Ultrasound/Other) used to identify your condition and dates: _____
_____
(You might be asked to bring them with you for your next appointment)

FOR FEMALES: Are you pregnant? _____ Weeks_____ Date of last period: _____

FINANCIAL ARRANGEMENTS

How do you plan to handle your account?
Insurance ___ Cash ___ Check ___ MasterCard ___ Visa ___ Discover ___ Amex ___

INSURANCE INFORMATION

Do you have personal, group health or accident insurance? ____ Name: _____
Subscriber Name: _____ Group Number: _____

(Attach copy of front and back of your insurance card)

I have read the above information and certify it to be true and correct to the best of my knowledge and hereby authorize this office to do whatever is necessary, in accordance with the state statues, for the care and management of this complaint.
DATED: _____ PATIENT'S SIGNATURE:_____
(Parent's signature if patient is minor)