

BARBARA KIRT, L.AC.

ACUPUNCTURE REGISTRATION FORM

(Please Print)

Today's date:		Primary Care Physician:				
PATIENT INFORMATION						
Patient's last name:		First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is your legal name?	(Former name):		Birth date: / /	Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Street address:				Home/Cell Phone Number: ()		
P.O. box:	City:	State:		ZIP Code:		
Occupation:	Employer:			Employer phone no.: ()		
Chose Acupuncture because (please check one box):				<input type="checkbox"/> Dr.		
<input type="checkbox"/> Family	<input type="checkbox"/> Friend	<input type="checkbox"/> Close to home/work	<input type="checkbox"/> Yellow Pages	<input type="checkbox"/> Other		
Other family members seen here:						

GENERAL INFORMATION	
Have you ever experienced Acupuncture before: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Are You Pregnant: <input type="checkbox"/> No/NA <input type="checkbox"/> Yes my due date is: _____	
Hospitalization: _____	When: _____
_____	When: _____
Medications: _____	

Please list any injuries you have sustained and the location. Are they still affecting you:	

Appliances (Screws, pacemakers, etc): _____	
Also, any treatments you are currently undergoing:	

IN CASE OF EMERGENCY			
Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ()	Work phone no.: ()
The above information is true to the best of my knowledge. I understand that I am financially responsible for any balance.			
_____ Patient/Guardian signature		_____ Date	