

Lori Guynes, Lic. Ac.
5370 Hollister Ave., Ste. B, Santa Barbara, CA 93111
(805) 681-6225/ (805) 681-6229 fax

REGISTRATION INFORMATION

Today's Date: _____

PLEASE PRINT

NAME: _____ **Birth Date:** _____ **AGE:** _____

ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:** _____

HOME #: _____ **WORK #:** _____ **CELL #** _____

Email address: _____ **Marital/Relationship Status:** _____

EMPLOYER: _____ **OCCUPATION:** _____

ADDRESS: _____

Person to notify in an emergency: _____ **Relationship:** _____

ADDRESS: _____

Home Phone: _____ **Other Phone:** _____

Who referred you to this office? _____ **Phone#:** _____

Private Pay / Insurance Info

Please Note: This Office does not bill insurance companies. However, we will be happy to enter your insurance information into our system so that you may submit a bill for reimbursement.

Insurance Co: _____ **Phone#:** _____ **FAX#:** _____

Claims Address: _____ **City:** _____

State: _____ **Zip:** _____ **Ins #** _____ **Group #** _____

WORKER'S COMPENSATION

Is this Work Comp related? YES _____ NO _____ **Claim#:** _____

Ins. Carrier: _____ **Adjusters Name:** _____ **Phone #:** _____

Referring MD: _____ **Phone #:** _____ **FAX #:** _____

MISSED APPOINTMENTS

This office charges **a \$65 fee** for missed appointments. A 'missed appointment' is one that is cancelled with **less than 24 hours notice.**

T E R M S and C O N D I T I O N S of S E R V I C E

ADMISSION/MEDICAL SERVICES AGREEMENT

The patient or the patient's representative consents to the treatment of the patient in this office as deemed necessary for the care of the patient. All of the terms and conditions listed below shall also apply to such treatment.

MEDICAL CONSENT

The patient or the patient's representative consents to any Oriental Medical treatments/procedures given under the general and special instructions of the attending Acupuncturist, or any other practitioner assisting in the care of the patient. The patient accepts the full responsibility to follow-up any medical advice given here.

The patient or patient's representative consents to the treatment procedure, its results, and any repercussions. The patient or the patient's representative accepts arbitration if deemed necessary.

RELEASE OF INFORMATION

This office is authorized to furnish, from the patients medical record, any necessary information to the referring physician (if any) and to others to the extent required in connection with a Claim's date of injury for aid, insurance, or medical assistance to which the patient may be entitled. The patient or the designated representative authorizes this office to release information to a collection agency to which the patients account may be referred or assigned for collection.

MEDICAL RECORDS

The patient or patient's representative hereby authorizes this office to obtain his/her medical records from previous medical history rendered by other physicians or medical centers.

ASSIGNMENT OF BENEFITS

In the event that my medical insurance company covers charges for acupuncture under my plan, I authorize payment of medical benefits be made directly to Lori Guynes, Lic. Ac., for the charges submitted on the medical claim form. *A copy of this authorization is as valid as the original.*

I understand that I am responsible for all payments for treatment. **Should recovery of payment by an outside agency be deemed necessary by the provider of treatment, I will pay all costs associated with such recovery.**

This office and the patient or the patient's representative hereby enter into this agreement. The patient certifies that s/he has read and accepted the 'Terms and Conditions of Service' as stated.

Signature

(Patient, Guardian, or Representative)

Date

PATIENT QUESTIONNAIRE

PRESENT COMPLAINT: (Symptoms, when and how the current problem and/or condition began; what, if anything, makes the symptoms better or worse)

CURRENT PRESCRIBED MEDS: _____

SUPPLEMENTS/HERBS: _____

DIET/LIFESTYLE CHOICES:

Smoke? _____ Alcohol? _____ Coffee? _____ Tea? _____ Soda? _____

Anything you don't or can't eat? _____

Do you exercise? _____ How often? _____ How long? _____

What type? _____

PHYSICAL HISTORY:

Date of last exam with a MD: _____ Name of MD: _____ Results of exam: _____

CHECK if you have had any of the following Disorders, Diseases, or Problems:

| | | | | | |
|------------------|-------|---------------------|-------|-----------------|-------|
| Blood | _____ | Gynecological | _____ | Psychological | _____ |
| Circulatory | _____ | Heart | _____ | Respiratory | _____ |
| Diabetes | _____ | High Blood Pressure | _____ | Skin | _____ |
| Ear/Nose/Throat | _____ | Kidney | _____ | Urogenital | _____ |
| Eyes | _____ | Liver | _____ | Other Problems: | _____ |
| Gastrointestinal | _____ | Musculoskeletal | _____ | | _____ |

IN GENERAL:

| | | | |
|------------------------------|-------|----------------------------|-------|
| Are you easily fatigued? | _____ | Are you generally thirsty? | _____ |
| Are you easily warmed? | _____ | Any trouble urinating? | _____ |
| Are you easily chilled? | _____ | Wake at night to urinate? | _____ |
| Do you have night sweats? | _____ | If so, how many times? | _____ |
| Do you sleep well? | _____ | Do you have constipation? | _____ |
| Do you have a good appetite? | _____ | Do you have diarrhea? | _____ |

FOR WOMEN:

| | | | |
|--------------------------------|-------|------------------------------------|-------|
| Date of last menstrual period: | _____ | Typical cycle length (ie, 30 days) | _____ |
| Pain with periods? | _____ | Light, medium, or heavy flow? | _____ |
| PMS? | _____ | Clots? | _____ |
| Birth Control Method: | _____ | Out of cycle bleeding? | _____ |

PLEASE LIST ALL OTHER PHYSICAL PROBLEMS YOU ARE EXPERIENCING (within the last year):
