=Lori Guynes, Lic. Ac.
5370 Hollister Ave., Ste. B, Santa Barbara, CA 93111
(805) 681-6225 Phone and 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 emergency: ______________________ Relationship: ________________

Phone #: ______________ How did you hear about this office/who referred you? ______________

INSURANCE INFORMATION

Please Note: This office does not bill insurance companies. However, we will be happy to provide you with a document that you may submit to your insurance for reimbursement.

Insured's name ________________ Ins. Co. ____________ PH#: ____________

Claims Address: ____

Insurance # __________________ 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 full appointment fee for missed appointments. A 'missed appointment' is a "no show," or a cancellation or rescheduling with **less than 24 hours notice**.

To show your understanding and agreement, **please initial here ____________

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

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

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