Energetic Medicine, PLLC

3216 NE 45th Place, Suite 301, Seattle, WA 98105; 206.472.1900

Personal Information (*Please print)*

Name ______________________________ Age ______________

Address ______________________________ Date of Birth ______________

City ______________ State ________ Zip Code ______________

Home Phone __________ Work Phone __________ Cell Phone ______________

E-mail Address ______________ Please initial that it is ok to email you at this address ______

Single / Married / Other Please initial that it is ok to leave a personal message on your cell phone ______

*****This section must be filled out for us to bill your insurance company*****

Insurance Company ______________________________

Insurance ID number______________ Insurance Group Number______________

Subscriber Name______________ **Subscriber date of birth**______________

Relation to patient______________ Insurance Effective Date ______________

Employer ______________________Occupation ______________________

Emergency Contact Name and Phone Number ______________________

Name and phone number of Primary Care Physician ______________________

Other Physicians and/or health care providers you are currently working with ______________

Who referred you to us for acupuncture services? ______________________

Primary reason for seeking acupuncture treatment ______________________

Other health concerns ______________________

Any history of hepatitis, HIV or other communicable disease? ______________________

Please list any medications or supplements you are currently taking ______________________

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Please list any medications, supplements or substances you are allergic to ______________

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Treatment Agreement

I agree to be treated with acupuncture and related techniques. I understand that no implied or stated guarantees have been given to me regarding cure or improvement of my condition as a result of treatment. Although my insurance company will be billed for reimbursement, there is no guarantee of insurance coverage. I understand that I am financially responsible for paying any portion of my bill that my insurance company does not cover. **I understand that missed appointments and appointments cancelled in less than 24 business hours will be charged a $62 fee.**

Patient Signature______________________Date______________________