Avery Acupuncture & Natural Medicine

New Patient Registration

Welcome to Avery Acupuncture & Natural Medicine. Our goal is to make your experience here as comfortable as possible. If you have any questions, comments, concerns or suggestions, please let Veronica or a staff member know. We thank you for placing your trust in us and you can expect us to deliver the highest quality of care possible.

Referred by: _____ Today's Date: _____

Patient Name: _____ Birth date: _____

Address: _____ Age: _____

City, State, Zip: _____ Gender: ____Female ____Male

Patient SSN: _____ Marital Status: Single Married Separated Divorced Widowed

Occupation: _____ Full time student?: Yes ☐ No ☐

Primary Care Physician: _____ Email: _____

Your Phone #: (_____)_____ (_____)_____
Home Cell

Emergency Contact: _____(_____)_____
Name Relationship to Patient Phone

<u>Primary Insurance Information</u>

Insured name: _____

Insured SSN: _____

Insured DOB: _____

Employer: _____

Payor/Health Plan:_____

Relationship to the insured: ☐Self ☐Spouse ☐Dependent

Member #: _____

Policy/Group #: _____

<u>Secondary Insurance Provider (if applicable)</u>

Insured name: _____

Insured SSN: _____

Insured DOB: _____

Employer: _____

Payor: _____

Relationship to the insured: ☐Self ☐Spouse ☐Dependent

Member #: _____

Policy/Group #: _____

Avery Acupuncture & Natural Medicine

New Patient Registration

Please describe you reason(s) for treatment at this time:_____

_____

Is this injury work related? ___Yes ___No Is this injury due to an auto accident? ___Yes ___No

How long have you had this condition?: _____

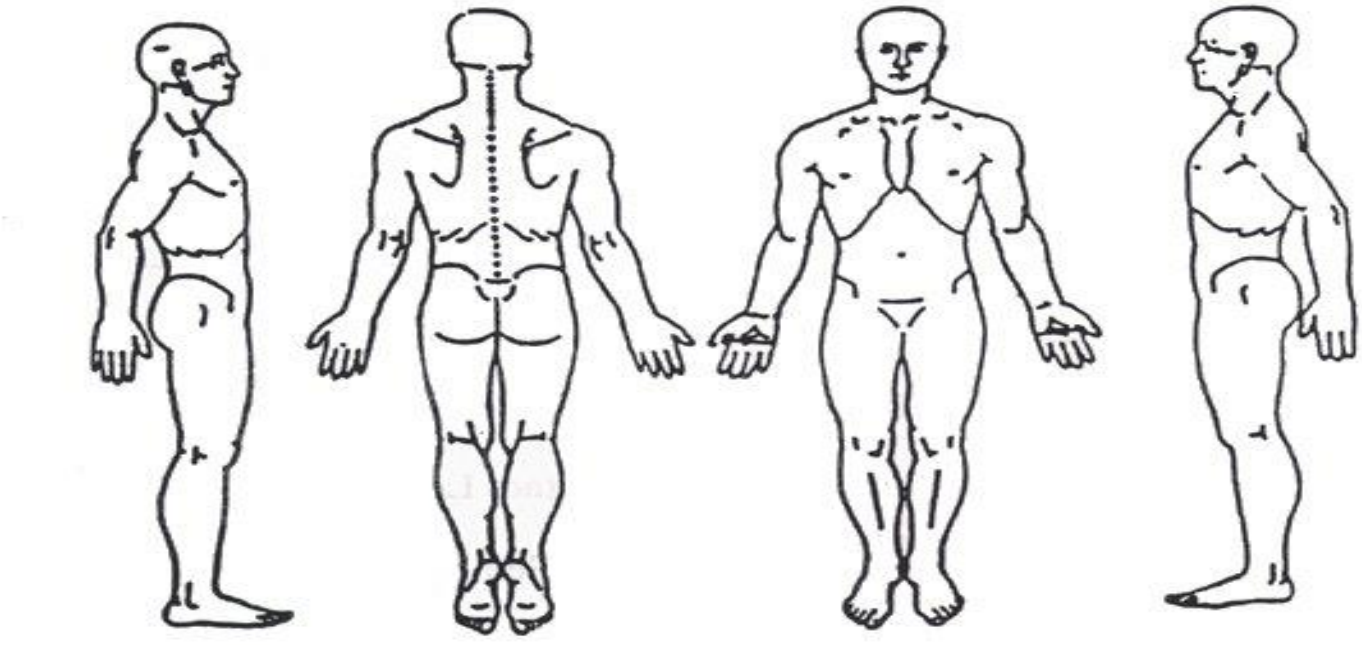
Does it bother your: ____Sleep ____Work ____Sex Life Other: _____

What do you feel was the initial cause? (if known):_____

Have you consulted another Doctor about these problems?: _____Yes _____No

If yes, Doctor's name, and diagnosis: _____
Please feel free to bring in any lab work, X-ray or MRI interpretation, etc.

Are you experiencing any discomfort in any areas of your body?: _____Yes _____No
If yes, using the models below, please indicate the appropriate location of the discomfort by using the symbol that best describes the feeling.



+ + + Sharp/Stabbing v v v Dull/Aching THE PAIN INDOCATED ABOVE IS:
o o o Pins & Needles / / / Numbness ____Mild ____Moderate ____Severe

Avery Acupuncture & Natural Medicine

New Patient Registration

YOUR PAST MEDICAL HISTORY

___Aids/HIV
___COPD
___Alcoholism/Drug Abuse
___Appendicitis
___Anemia
___Asthma
___Arthritis
___Depression
___Birth Trauma
___Cancer/Tumor
(type:_____)

___Diabetes
___Eczema
___Epilepsy
___Glaucoma
___Gout
___Heart Disease
___Hepatitis (type: _____)
___Herpes
___High Blood Pressure
___Mental Disorder
___Migraines

___Pacemaker
___Pleurisy
___Pneumonia
___Rheumatic Fever
___Seizures
___Sciatica
___Stroke
___Thyroid Disorders
___Ulcers

___Allergies(food,drug,pollen)
_____
_____
___Major Trauma
_____
_____

List of previous illness/hospitalizations or surgeries:_____

_____

List of any current medicines, homeopathics, vitamins, minerals, or herbs you are taking now:

_____ _____ _____

_____ _____ _____

_____ _____ _____

Lifestyle/Nutrition

Average Daily Menu

☐Alcohol
__Tobacco
__Stress
__Caffeinated Tea
__Coffee
__Soft Drinks
__Sugar
__Artificial Sweetener

a.m. _____
_____
noon_____
_____
p.m._____
_____

Regular Exercise

Type: Frequency:

_____ _____
_____ _____

Avery Acupuncture & Natural Medicine

New Patient Registration

General

__Poor Appetite
__Weight Gain
__Weight Loss
__Strong Thirst
__Night Sweats

__Fever
__Sweating Easily
__Chills
__Tremors
__Insomnia

__Disturbed Sleep
__Localized Weakness
__Sudden Energy Drop
(time of day?: _____)
__Bleeding or Bruising Easily

Head, Eyes, Nose, Throat / Skin

__Dizziness
__Glasses
__Poor Hearing
__Dry Throat
__Sinus Problems
__Grinding Teeth
__Nose Bleeds

__Spots in front of eyes
__Poor Vision
__Cataracts
__Earaches
__Dry Mouth
__Recurrent sore throats
__Mucus

__Sores on lips or tongue
__Migraines
__Ringing in ears
__Blurry Vision
__Headaches
(Location:_____)
(When:_____)

__Rashes
__Hives
__Eczema
__Psoriasis

Cardiovascular

__Low Blood Pressure
__Chest Pain
__Irregular Heart Beat
__High Blood Pressure

__Fainting
__Swelling of Hands
__Cold Hands/Feet
__Swelling of Feet

__Blood Clots
__Difficulty in Breathing

Any other heart or blood vessel problems:_____

Respiratory

__Cough
__Coughing up Blood
__Asthma

__Bronchitis
__Pain with deep inhalation
__Difficulty in breathing when lying down

__Excessive phlegm or color
(color:_____)

Gastrointestinal

__Nausea
__Vomiting
__Diarrhea

__Constipation
__Gas
__Belching

__Black Stools
__Blood in Stools
__Acid Reflux

__Bad Breath
__Rectal Pain
__Hemorrhoids

__Abdominal Pain
__Chronic Laxative use

Do you have daily bowel movement?: _____Yes _____No How often?:_____

Formed_____ Loose_____ Hard_____

Avery Acupuncture & Natural Medicine

New Patient Registration

Urinary

__Pain with urination
__Frequent urination
__Blood in urine
__Urgency to urinate
__Kidney Stones
__Unable to hold Urine
__Decrease in flow
__Burning with urination

Do you wake up to urinate? _____ If so, how often?_____

Any particular color to your urine? _____

Any other genital or urinary problems? _____

Reproductive and Gynecologic (Women)

__Breast Tenderness
__Menstrual clots
__Painful Menses
__Sexually Transmitted Diseases
__Heavy menstrual flow
__Light menstrual flow
__Irregular menses
__Cramps
__Premature births
__Miscarriages
__Abortions
__Infertility

Age at first menses_____ Age at menopause _____ Number of live births_____

Number of days between cycles _____ Number of days bleeding _____ First day of last menses_____

Do you practice birth control? _____ If so, what type? _____ For how long? _____

Any other gynecologic problems? _____

Urogenital/Reproductive (Men)

__Testicular swelling/pain
__Premature ejaculation
__Nocturnal emissions
__Weak or slow urine stream
__Dribbling urination
__Burning urination
__Discharge from penis
__Rectal/anal pressure
__Low sperm count
__Impotence
__Decreased sex drive
__Increases sex drive

Any other questions, comments or concerns:_____

_____

Avery Acupuncture & Natural Medicine

New Patient Registration

FINANCIAL TERMS

Upon verification of health plan/insurance coverage and policy limits, your insurance carrier will be billed for you and your provider will be paid directly by the carrier. You will be responsible for any applicable deductions and copayments. Copayments must be paid at the time services are rendered. If you are not eligible at the time services are rendered, you are responsible for full payment.

CANCELED/MISSED APPOINTMENTS

A scheduled appointment means that time is reserved only for you. If an appointment is missed or canceled with less than 24 hours notice, you will be billed directly according to the scheduled fee or according to the rules of your health plan. Your health plan does not cover payment for missed appointments; therefore, you are responsible for payment in full.

A cancellation fee of $50.00 will be applied with less than 24 hours notice of scheduled appointment.

I have read, or have had read to me, the above consent and other information. I have also had an opportunity to ask questions about its content, and by signing below, I agree to the above named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I may seek treatment.

Patient (or parent/guardian) name – Signature Date

May we contact you via text message to remind you of your upcoming appointments? Y / N

Signature _____