# Grace Acupuncture and Oriental Medicine

## Patient Information

FIRST NAME MIDDLE LAST NAME | ADDRESS CITY STATE ZIP

HOME PHONE | CELL PHONE | EMERGENCY PHONE# | EMERGENCY CONTACT NAME / RELATION

/ /

DOB SEX MARITAL STATUS | PAGER | RACE (optional)

PRIMARY CARE PHYSICIAN | STUDENT? FT OR PT | OTHER NAMES

EMPLOYER NAME | EMPLOYER ADDRESS | EMPLOYER PHONE

## Billing Information

## (If different than patient)

FIRST NAME MI LAST NAME | ADDRESS CITY STATE/ZIP PHONE

## Primary Insurance Information

INSURANCE NAME | EFFECTIVE DATE | MEDICAL CLAIMS ADDRESS

SELF SPOUSE CHILD OTHER

GROUP ID# | POLICY ID# | RELATIONSHIP OF PATIENT TO SUBSCRIBER

SUBSCRIBER NAME (POLICY HOLDER) | SUBSCRIBER ADDRESS (if different than patient) | SUBSCRIBER PHONE (if different than patient)

/ /

SUBSCRIBER DATE OF BIRTH | SUBSCRIBER SEX | SUBSCRIBER SSN# | CO-PAY AMOUNT

SUBSCRIBER EMPLOYER | EMPLOYER ADDRESS | EMPLOYER PHONE#

## Secondary Insurance Information

INSURANCE NAME | EFFECTIVE DATE | MEDICAL CLAIMS ADDRESS

SELF SPOUSE CHILD OTHER

GROUP ID# | POLICY ID# | RELATIONSHIP OF PATIENT TO SUBSCRIBER

SUBSCRIBER NAME (POLICY HOLDER) | SUBSCRIBER ADDRESS (if different than patient) | SUBSCRIBER PHONE (if different than patient)

/ /

SUBSCRIBER DATE OF BIRTH | SUBSCRIBER SEX | SUBSCRIBER SSN# | CO-PAY AMOUNT

SUBSCRIBER EMPLOYER | EMPLOYER ADDRESS | EMPLOYER PHONE#

By signing this form, I am consenting to Grace Acupuncture and Oriental Medicine's use and disclosure of my Protected Health Care Information, including information related to psychiatric care, drug and alcohol abuse and HIV/AIDS for the purpose of carrying out treatment, payment and healthcare operations. I have been provided or offered a copy of Grace Acupuncture and Oriental Medicine's Privacy Statement. I assign all medical benefits to Grace Acupuncture and Oriental Medicine for services rendered. By signing this form I am confirming that the above demographic and insurance information is current and correct. If the information is not correct I understand I will be held responsible for all charges incurred in today's visit.

*The effective period of this authorization is from today's date to a future date, when I am no longer a patient of* ***Grace Acupuncture and Oriental Medicine*** *or am deceased.*

PERSON GIVING CONSENT | RELATIONSHIP IF NOT THE PATIENT | DATE