

Life Gate Acupuncture

Patient Information

Date: _____

Name _____
Last Name First Name Initial

Address _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Is it OK to leave a message at? Home Work Cell Birthdate _____ Age _____

Email _____ Is it OK to contact you through email regarding health issues? Yes No

Is it OK to send appointment reminders through email? Yes No

Gender: _____ Sex identified on insurance: M F _____

Single Married Divorced Other

Employer: _____ Occupation _____

Business Address _____

City _____ State _____ Zip _____

Primary Care Physician: _____ Phone _____

Address _____

City _____ State _____ Zip _____

Date of Last Physician Visit: _____

Primary Health Insurance _____

Name of Insured: _____
Last Name First Name Initial

Relation to Insured _____ Insured's ID number _____ Group # _____

Address (if different) _____

City _____ State _____ Zip _____

Secondary Insurance? Yes No Plan Name _____ ID Number _____

Who may we thank for referring you? _____

In Case of Emergency Please Notify: _____ Phone _____

Assignment:

I, _____ certify that I (or my dependents) have coverage with _____ and assign directly to Kara Romanko, L.Ac. all insurance benefits, if any, otherwise payable to me for services rendered. I understand I am financially responsible for all charges whether or not paid by insurance. I hereby authorize Kara Romanko, L.Ac., to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature

Relationship

Date