Kara Romanko, DAOM, L.Ac.

Patient Information

co-pay_____

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 ☐

Sex: ☐ M ☐ F ☐ Transgender ☐ 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