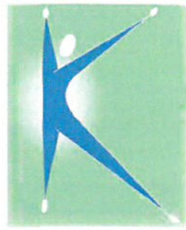

Knewtson Health Group

New Patient
Adult

Name ______
Address ______
City ______ State ______ ZIP ______
Phone Numbers (Home) ______ (Cell) ______
Is it O.K. to contact you at work? O Yes O No Work # ______
E-mail Address ______
SS# ______ Birthdate ______ Age ______
Occupation ______ Employer ______
Marital Status O Single O Married O Separated O Divorced O Widowed
Spouses Name ______ Phone Number(s) ______
Children's Names and ages ______

______
Emergency contact name ______
Relationship ______ Phone Number(s) ______
Favorite hobbies and interests ______

Financial Responsibility

Who is responsible for payment? ______

How will you pay for your care? ______

Insurance Co. ______ Group Policy # ______

Address ______ Phone # ______

Policy Holder's Name ______ Policy Holder's DOB ______

Relation ______ Policy Holder's Employer ______

What Brings you here?

Have you ever had chiropractic care? O Yes O No
If yes, please tell us the doctor's name. ______
Were you pleased with your care? O Yes O No
How did you find out about our office? ______
Is this appointment related to: O Work O Sports O Auto O Personal Injury O Other

______

ACUPUNCTURE CONSENT TO TREATMENT

-I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of practice of acupuncture. These procedures may include the insertion of small, sterile, single-use, disposable needles through the skin and into the body at specific points, the use of a small electrical current on pre-inserted needles (electro-acupuncture), a deep-tissue massage technique (Gua Sha) performed with a hand held tool made of plastic or ceramic, the use of glass or plastic cups that have been slightly heated and placed on the skin (cupping), and bleeding techniques with the use of a small lancet alone or in conjunction with cupping.
-I understand that acupuncture is generally a safe method of treatment, but that there has been documented adverse effects including, but not limited to, bruising, dizziness/fainting, nausea, and numbness or tingling near the needling site following treatment. In rare cases there is the possible risk of infection at the insertion site, pnuemothorax, scarring, or spontaneous miscarriage. I understand that Knewtson Health Group uses clean-needle standards and safety procedures to reduce the risk of any possible adverse effects.
-I understand it is my responsibility to inform Knewtson Health Group staff performing acupuncture of any changes to my health, including pregnancy, use of anti-coagulant drugs, bleeding disorders, blood borne diseases such as HIV or hepatitis, cancer/malignancies, metal implants, or pacemaker placement prior to treatment.
-I understand that acupuncture is an elective service done in conjunction with chiropractic care and may not be covered by insurance. I understand that if my insurance does not cover treatment that I am required to pay for this service by cash, check, or credit card prior to receiving acupuncture treatment. I understand I may independently submit charges I directly pay for acupuncture care to my insurance carrier for reimbursement.

By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment and have been told the risks and benefits of acupuncture treatment.

Name: ______________________________ Date: ________________________

Signature: ____

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