Eastern Ways Acupuncture & Health Center

18731 N. Reems Rd., Suite 640 * Surprise, AZ 85374
(623) 584 – 6200

Patient Information

The following information is important to the maintenance of your account and/or your care. Please answer all the questions to the best of your ability. We are happy to help if you require some assistance in the completion of the forms.

PATIENT INFORMATION

Name: ____ Male or Female

Date of Birth: ____/____/____ Age: _______ SSN: _____-_____-_____

Address: ____________________________ City: _______________ State: _____ Zip: _________

Home Phone: ________________ Work Phone: ________________ Cell Phone: ________________

Email: ____ Fax: ________________

Status: Single Married Divorced Separated Widowed

Occupation: ____________________________________ Employer: ______________________

RESPONSIBLE PARTY

Name of Responsible Party: ________________________________ Relationship: ______________

Address: ____________________________ City: _______________ State: _____ Zip: _________

Home Phone: ________________ Work Phone: ________________ Cell Phone: ________________

Email: ____ Fax: ________________

INSURANCE INFORMATION

Primary Insurance Company: ________________________________ ID#: ____________________

Address: ____________________________ City: _______________ State: _____ Zip: _________

Customer Service Phone #: ________________________

Subscriber Date of Birth: ____/____/____ Subscriber Relationship to Patient: ________________________

Secondary Insurance Company: ________________________________ ID#: ____________________

Address: ____________________________ City: _______________ State: _____ Zip: _________

Customer Service Phone #: ________________________

Subscriber Date of Birth: ____/____/____ Subscriber Relationship to Patient: ________________________

EMERGENCY CONTACT

Name: ___________________________ Phone: _______________ Relationship: ____________

Name: ___________________________ Phone: _______________ Relationship: ____________

Name: ___________________________ Phone: _______________ Relationship: ____________

AUTHORIZATION TO RELEASE PATIENT INFORMATION & AUTHORIZATION TO PAY

I hereby authorize Eastern Ways Acupuncture & Health Center to release any personal health information (PHI) required in the course of my examination or treatment to the above stated insurance company, or their affiliates and I hereby authorize insurance payment directly to Eastern Ways Acupuncture & Health Center, for medical services rendered.
I understand that I am financially responsible for the charges not covered by my insurance. In the event of default, I promise to pay collection costs and reasonable fees as may be required to obtain collection of this account.

Signed (Patient or guardian)____ Date______________