

# Welcome to



# PETER LING ACUPUNCTURE

Please take a moment to provide us with some information about yourself and your health conditions, so that we may do our best to treat you. We consider this information privileged physician/patient communication and will hold it in confidence.

## Patient Information

Date: \_\_\_\_\_

Phone for follow-up: \_\_\_\_\_

Patient's Name: First \_\_\_\_\_ Mi \_\_\_\_\_ Last \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone (\_\_\_\_\_) \_\_\_\_\_ Cell Phone (\_\_\_\_\_) \_\_\_\_\_

Sex:  Male  Female Date of Birth: \_\_\_\_\_ Social Security No. 

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Age: \_\_\_\_\_ Present Weight: \_\_\_\_\_ LBS Height: \_\_\_\_\_ Driver's License # \_\_\_\_\_

Widowed  Separated  Divorced  Single  Married

Do you drink?  Yes  No Do you Smoke?  Yes  No

If yes, smoke \_\_\_\_\_ Pack(s) a day / been smoking for \_\_\_\_\_ Years

Patient Employed By \_\_\_\_\_

Business Address \_\_\_\_\_

Occupation \_\_\_\_\_ Business Phone (\_\_\_\_\_) \_\_\_\_\_

In case of emergency who should we notified? \_\_\_\_\_

Relationship with patient \_\_\_\_\_ Phone (\_\_\_\_\_) \_\_\_\_\_

Address \_\_\_\_\_

Primary Physician \_\_\_\_\_ Phone (\_\_\_\_\_) \_\_\_\_\_

Address \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_ Phone (\_\_\_\_\_) \_\_\_\_\_

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_