# INTEGRATED MEDICAL CENTER OF CORONA

**GENERAL INFORMATION:**

Name: ______________________________ Birthdate: __________ Age: ______ Sex: M / F

Social Security Number: ______________ Driver's License No. & State: ________________ Expiration: ________

Home Street Address: ______________________________________________

City: ______________________ State: _______ Zip: _______________

Home Phone: __________________ Business Phone: __________________ Cell/Other: __________________

Business/Employer: ______________________________ Occupation: ______________________

Employer Address: ______________________________________________

Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated No. of Children: _______

Spouse's Name: ____________________ Spouse's Business/Employer: ______________________

Employer Address: ______________________________ Employer's Phone: ________________

Name of Emergency Contact: ______________________________ Phone: __________________

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***For Minors (Under 18 Years Old):***

1) In the Custody of (Choose One): ☐ Both Parents ☐ Mother ☐ Father ☐ Other (Specify): ____________________

2) Lives With (Choose One): ☐ Both Parents ☐ Mother ☐ Father ☐ Other (Specify): ________________________

3) Mother's Name: ____________________ Home Phone: _______________ Work Phone: _______________

Address: ______________________________________________

4) Father's Name: ____________________ Home Phone: _______________ Work Phone: _______________

Address: ______________________________________________

5) Other Contact's Name: _______________ Home Phone: _______________ Work Phone: _______________

Address: ______________________________________________

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***Insurance Information:***

1) Primary Insurance Company Information:

Name: ______________________ Ins. Type (Choose One): ☐ HMO ☐ PPO ☐ Other (Specify): __________

Street Address: ______________________________________________

City: ____________________________ State: ______ Zip Code: ______________

Phone: ______________________ Effective Date: ______________

Group No.: _______________________ Certificate No.: ________________________

Relationship to Subscriber: ____________________ Subscriber's Name: ______________________

Subscriber's Social Security No.: _______________________ Subscriber Date of Birth: ____________

2) Secondary Insurance Company Information:

Name: ______________________ Ins. Type (Choose One): ☐ HMO ☐ PPO ☐ Other (Specify): __________

Street Address: ______________________________________________

City: ____________________________ State: ______ Zip Code: ______________

Phone: ______________________ Effective Date: ______________

Group No.: _______________________ Certificate No.: ________________________

Relationship to Subscriber: ____________________ Subscriber's Name: ______________________

Subscriber's Social Security No.: _______________________ Subscriber Date of Birth: ____________

**SEE BACK SIDE**

Who is responsible for payment of your bill? ☐ Myself (cash) ☐ Worker's Comp. ☐ Medicare ☐ Auto Insurance

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***Current health condition:***

Purpose of this appointment:______________________________

Other doctors seen for this condition: ______________________________

When did this condition begin: ______________________________

Current medications: ______________________________

Females Only: Are you pregnant? Yes / No Date of last menstrual cycle (period): _______________

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***Past medical history:***

Have you had previous Chiropractic care? Yes / No If so, when: _____________ Was it a positive experience? Yes / No

Prior surgeries (procedure and dates of): ______________________________

______________________________

Major accidents/falls: ______________________________

______________________________

Prior &/or current illness(es), even if apparently unrelated to current condition: ______________________________

______________________________

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Who referred you to our office? ______________________________

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*I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that CICPN will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Doctor's office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment any fees for professional services rendered me will be immediately due and payable.*

*The above is true and correct to the best of my knowledge.*

Patient or Guardian Signature:__________________________________________________ Date: ______________

## INFORMED CONSENT FOR ACUPUNCTURE TREATMENT & CARE

I hereby request and consent to the performance of acupuncture treatments and other Oriental Medicine procedures, including various modes of physio-therapy on me(or on the patient named below,for whom I am legally responsible) by the below named licensed acupuncturist and/or other licensed acupuncturist who now or in the future treat me while employed by,working or associated with or serving as a back-up for the treating acupuncturist named below,including at this office/clinic or any other office or clinic.

I understand that methods or treatment may include, but are not limited to, acupuncture, moxibustion, cupping,electrical simulation, Tui-Na(Chinese massage), Chinese or Western herbal medicine, and nutritional counseling.

I have had the opportunity to discuss with the acupuncturist named below and/or with other office or clinic personnel the nature and purpose of acupuncture treatments and other procedures.

Acupuncture has the effect to normalize physiological functions, to modify the perception of pain, and to treat certain diseases or dysfunctions of the body. I have been informed that acupuncture is a safe method of treatment, but occasionally there may be some bruising or tingling near the needling sites that last a few days. There have been very rare instances reported of fainting, infections and scarring. There have been extremely rare instances reported of spontaneous miscarriage and pneumothorax. There may be some bruising after cupping.

The herbs and nutritional supplements(which are from plant, animal and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine. I understand that some herbs may be inappropriate during pregnancy. If I experience any gastro-intestinal upset or allergic reactions to the herbs I will inform the acupuncturist.

I do not expect the acupuncturist to be able to anticipate and explain all risks and complications, and I wish to rely on the acupuncturist to exercise judgment during the course of the procedure which the acupuncturist feels at the time, based upon the facts then known, is in my best interests.

I understand the clinical and administrative staff may review my medical records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

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*To be completed by the patient:*

PATIENT'S NAME ______________________________
(PLEASE PRINT)

PATIENT'S SIGNATURE ______________________________

DATE SIGNED ______________________________

ARE YOU PREGNANT? ☐YES ☐NO

NAME OF CLINIC/OFFICE ______________________________

*To be completed by the patient's representative, If necessary,e.g., If the patient is a minor is physically or legally incapacitated:*

NAME OF PATIENT ______________________________
(PLEASE PRINT)

PATIENT'S REPRESENTATIVE ______________________________
(PLEASE PRINT)

RELATIONSHIP OR AUTHORITY OF PATIENT ______________________________

WITNESS ______________________________

NAME(S) OF TREATING ACUPUNCTURIST(S): ______________________________