BILL PRANGE
LICENSED ACUPUNCTURIST
DOCTOR OF ORIENTAL MEDICINE

TODAY'S DATE ____________________

NEW PATIENT INTAKE FORM

NAME ____________________________________ BIRTHDATE ____________________ AGE ________

ADDRESS __________________________________ HEIGHT _____________ WEIGHT ______________

CITY, STATE, ZIP ____________________________ OCCUPATION ______________________________

HOME PHONE _______________________________ WORK PHONE _____________________________

EMAIL ____________________________________ REFERRED BY ______________________________

EMERGENCY CONTACT (NAME & PHONE) ____

REASON FOR TODAY'S VISIT ____

HOW LONG HAVE YOU HAD THIS CONDITION? ____

IS IT GETTING WORSE? ____

DOES IT BOTHER YOUR SLEEP? ____ WORK? ______ OTHER (WHAT)? ______________________

WHAT SEEMED TO BE THE INITIAL CAUSE? ____

WHAT SEEMS TO MAKE IT WORSE? ____

____

____

WHAT SEEMS TO MAKE IT BETTER? ____

____

____

ARE YOU UNDER THE CARE OF A PHYSICIAN NOW? YES ____ NO ____ IF YES, FOR WHAT? ______________

PHYSICIAN'S NAME _____________________________________ PHONE _________________________

OTHER CONCURRENT THERAPIES ____

____

HAVE YOU HAD ACUPUNCTURE BEFORE? ________________ CHINESE HERBAL MEDICINE? ________________

SIGNATURE TO RELEASE MEDICAL INFORMATION:

I understand that I am personally responsible for the payment of services rendered by Dr. Prange, and a 48 hour notice of cancellation is required to avoid a missed appointment fee of $62.50. ________________________________

NOTICE OF PRIVACY PRACTICES:

I have received a copy of the Notice of Privacy Practices ______________________________

I have elected not to receive a copy of the Notice of Privacy Practices __________________________

drprange.com • 1020 Gravenstein Hwy, South, Suite 100 • Sebastopol, CA 95472 • 707.829.1991