

Kim D. Kelly, ND, MPH

Encinitas Acupuncture & Massage
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Patient Information Form

Last Name: _____ First Name: _____ M.I. _____ Today's Date: _____

Other names or nicknames your records may be kept under: _____

Mother's Name (minors only) _____ Father's Name (minors only) _____

Address: _____ Apartment #: _____

City: _____ State: _____ Zip code: _____ Home Phone: (____) _____

Cell Phone: (____) _____ Work Phone: (____) _____ E-mail: _____

Occupation: _____ Employer/School: _____

Date of Birth: _____ Gender: _____

Emergency Contact: _____ Contact's Phone #: (____) _____

Are you hearing impaired? Y N Are you visually impaired? Y N Do you need an interpreter or TTY line? Y N

Do you have non-English language needs?: _____ (or) Special needs?: _____

How did you hear about us? _____

I, the undersigned, pledge that the above information is accurate and complete to the best of my knowledge. I understand that payment is due at the time of service for all visits at the clinic unless prior arrangements have been made. I understand that if I am providing insurance billing information, I am financially responsible for all charges whether or not they are paid by my insurance. I hereby authorize Kim D. Kelly, ND, MPH to release all information necessary to secure the payment of insurance benefits, and I authorize the use of this signature on all my insurance submissions.

X _____

Signature of patient*

date

X _____

Signature of guardian

date

Relationship to patient: _____

* Guardian's signature required for minors.