# Kim D. Kelly, ND, MPH

Encinitas Acupuncture & Massage
121 West E Street
Encinitas, CA 92024

Phone: (760) 533-2883 Fax: 1-866-353-3603


## 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____________________________ _______ X____________________________ _______

Signature of patient* date Signature of guardian date

Relationship to patient: ___________________

* Guardian's signature required for minors.