KIM WELLNESS Acupuncture, LLC.

PATIENT REGISTRATION

PATIENT INFORMATION

Name(Last, First, Middle): _____ Soc. Sec. #: _____

Date of Birth: _____ Age: _____ Sex: ☐Male / ☐Female Marital Status: ☐Single/ ☐Married/ ☐Widowed/☐Divorced/☐Other

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: (_____) _____ Cell / Work Phone: (_____) _____ Occupation: _____

Employer/School Name & Address: _____

Emergency Contact Person: _____ Phone: (_____) _____

PRIMARY INSURANCE

Name of Insurance Company: _____ Date of Accident: _____

ID # / Policy #: _____ Claim #: _____

Policyholder (if other than patient): _____ Relationship: _____

Soc. Sec. #: _____ Date of Birth: _____ Phone: (_____) _____

SECONDARY INSURANCE

Name of Insurance Company: _____ Name of Plan: _____

ID #: _____ Group #/Policy #: _____

Policyholder (if different from patient): _____ Relationship: _____

Soc. Sec. #: _____ Date of Birth: _____ Phone: (_____) _____

FOR OFFICE USE ONLY

Copay: _____ Pre-Authorization needed: ☐No / ☐Yes (if yes, ☐ Orthonet / ☐ Procedure: _____)

Referral Needed: ☐No / ☐Yes Maximum # PT Visits: _____ (so far used: _____) After Max Visits: _____

Deductible/Coinsurance.: _____ /yr (so far used:_____) Note: _____

AUTHORIZATIONS & SIGNATURE

☐ INSURANCE ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to
Name of Insurance Company(ies)

Kim Wellness Acupuncture Care all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. Shinbi Acupuncture Care may use my health care information and may disclose such information to the above-named Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

☐ MEDICARE/MEDIGAP AUTHORIZATION

I request that payment of authorized Medicare benefits and, if applicable, Medigap benefits, be made either to me or on my behalf to Kim Wellness Acupuncture Care for any services furnished to me by Shinbi Acupuncture Care To the extent permitted by law, I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services, my Medi gap insurer, and their agents any information needed to determine these benefits or benefits for related services.

Signature: _____ Today's Date: _____

Name (please print): _____ Relationship to patient: _____

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PATIENT MEDICAL INFORMATION (CONFIDENTIAL)

CHIEF COMPLAINT(S)/INJURY DESCRIPTION

• Chief Complaint(s): _____

• Onset date: when did this symptom(s) begin?_____ • Have you had this symptom(s) before? ☐ No ☐ Yes: when?_____

• Is this an injury? ☐ No ☐ Yes: Date of Accident/Injury: _____/_____/_____ Time: _____:_____(AM/PM) Location: _____

Nature of the injury: ☐ Auto Collision ☐ On-the-Job Injury ☐ Other • Description: _____

If auto accident, you were a☐ Driver/☐ Passenger/☐ Pedestrian and struck from ☐ Behind/☐ Rt. Side/☐ Lt. Side/☐ Front/☐ Auto was parked

If an Attorney is involved, Attorney's Name: _____ Phone: (_____) _____

• Are you currently working? ☐ N/A ☐ No ☐ Yes: if no, last date worked: _____ if yes, any restrictions? _____

•Have you had Surgery for this injury? ☐ No ☐ Yes: Type of surgery: _____ Date of surgery: _____

• Medical Care/Treatment related to current condition/injury (check all that apply and write date of the care/treatment)

☐ X-ray _____ ☐ Primary Doctor _____ ☐ Orthopedic Dr._____ ☐ Neurologist _____

☐ MRI _____ ☐ Chiropractor _____ ☐ Physical Therapy _____ ☐ Other: _____

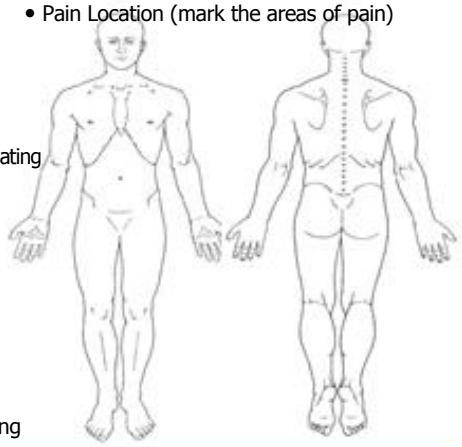
• Have you received any Acupuncture Service this year? ☐ None ☐1-5visits ☐6-10visits ☐11-15visits ☐16-20visits ☐> 21 visits

PAIN HISTORY/DESCRIPTION

• How would you rate the pain on scale of 0-10? (mark ○ for current pain, × when it's worse)

0	1	2	3	4	5	6	7	8	9	10
No Pain		Mild Pain		Moderate		Severe		Very Severe		Worst

• Pain Location (mark the areas of pain)



• Pain Description (mark all that apply)

☐ Sharp ☐ Stabbing ☐ Dull ☐ Aching ☐ Burning ☐ Numb/Tingling ☐ Spasm/Stiff ☐ Radiating

•What makes it better? Activity: _____ Time of day: _____

•What makes it worse? Activity: _____ Time of day: _____

Check those activities below during which you experience difficulty:

☐ Pulling ☐ Pushing ☐ Lifting ☐ Bending forward/backward ☐ Squatting ☐ Sitting for long time

☐ Sit to Stand ☐ Standing for long time ☐ Walking ☐ Stair Climbing ☐ Running ☐ Sports

☐ Dressing ☐ Toileting ☐ Bathing ☐ Getting in/out of car ☐ Sexual Activity ☐ Grocery Shopping

MEDICAL CONDITIONS/MEDICATIONS

• Do you have, or have you had any of the following? (mark all that apply)

☐ AIDS/HIV Positive	☐ Epilepsy	☐ Osteoporosis	☐ Endometriosis
☐ Allergies	☐ Gout	☐ Pacemaker	☐ Miscarriage
☐ Anemia	☐ Heart Attack	☐ Parkinsonism	☐ Pelvic Inflammatory Disease
☐ Arthritis	☐ Hepatitis	☐ Pneumonia	☐ Vaginal Infections
☐ Asthma/Bronchitis	☐ Hernia	☐ Prostate Problem	☐ Pins/Metal Implants:_____
☐ Blood Clot	☐ High Blood Pressure	☐ Sleeping Problems	☐ Joint Replacement: _____
☐ Cancer:_____	☐ High Cholesterol	☐ Stroke/TIA	☐ Neck/Back Surgery
☐ Cataracts/Glaucoma	☐ Kidney Disease:_____	☐ Thyroid Problems	☐ Shoulder/Arm/Hand Surgery
☐ Coronary Heart Disease/Angina	☐ Liver Disease: _____	☐ Ulcers:_____	☐ Knee/Ankle/Foot Surgery
☐ Diabetes	☐ Migraine/Headaches	☐ Incontinence(Urinary/Fecal)	☐ Heart Surgery: _____
☐ Emphysema/COPD	☐ Multiple Sclerosis	☐ Complicated Pregnancy/Delivery	☐ Other Organ Surgery:_____

☐ List Medications/Drugs/Supplements/Herbs you are currently taking: _____