



VERMONT CHINESE ACUPUNCTURE

HEALTH INFORMATION FORM

NAME: _____ DATE: _____

ADDRESS: _____

CITY: _____ STATE: _____

ZIP: _____

PHONE: _____ E-MAIL _____

DATE OF BIRTH: _____

PLACE OF WORK: _____

INSURANCE: _____ # _____

POLICY OR GROUP NAME: _____

WHO REFERRED YOU TO THIS OFFICE _____

OR

HOW DID YOU HEAR ABOUT THIS OFFICE _____

This information is strictly confidential.

WHAT WOULD YOU LIKE HELP WITH TODAY _____

LIST SURGERIES & MAJOR MEDICAL PROCEDURES _____

LIST MEDICATIONS, HERBS, SUPPLEMENTS: