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Professional Unit #2
White Plains, NY 10601
914-285-3480 (P)
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Xin Quan M.D.
Xin Quan Medical Rehabilitation
& Acupuncture, PLLC
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REGISTRATION FORM

PATIENT INFORMATION			
Last Name, First Name:	Phone #:	Marital Status: Single / Married / Div / Other	
Do You Have Another Name? ☐ No ☐ Yes If Yes:	Social Security #:	Birth Date: / /	Gender: ☐ M ☐ F
Address: City: State: Zip Code:			
Occupation: ☐ Retired	Who Referred You? ☐ Friend: _____ ☐ Other ☐ Dr. _____ ☐ Hospital: _____		
Emergency Contact Last Name, First:	Relationship to Pt:	Phone #:	

FOR PURPOSE OF COMMUNICATION WITH YOUR DOCTORS	
Pharmacy:	Phone # and Address:
Primary Physician:	Phone # and Address:
Referring Physician:	Phone # and Address:

INSURANCE INFORMATION		
Primary Insurance:	Policy Holder's Name: ☐ Self	
Pt's Relation to Policy Holder : ☐ Spouse ☐ Child ☐ Other	Date Of Birth of Policy Holder: / /	Social Security #:
Secondary Insurance:	Policy Holder's Name: ☐ Self	
Pt's Relation to Policy Holder : ☐ Spouse ☐ Child ☐ Other	Date Of Birth of Policy Holder: / /	Social Security #:
Tertiary Insurance:	Policy Holder's Name: ☐ Self	
Pt's Relation to Policy Holder : ☐ Spouse ☐ Child ☐ Other	Date Of Birth of Policy Holder: / /	Social Security #:

WORKERS COMPENSATION/NO-FAULT	
Is this condition related to: ☐ Work ☐ Motor Vehicle Accident ☐ Other	Date of Accident: / /
Claim/Case #:	Adjuster's Name and #:
Policy Holder's Name:	
Employer Name and #: Address:	Worker's Comp/Auto Insurance Name: Address:

HEALTH HISTORY

Do You Smoke: ☐ Never ☐ Former Smoker; Date Stopped: ☐ Yes; How Frequent:

Do You Drink Alcohol: ☐ Never ☐ Yes; How Often:

Have You Ever Taken Illegal Drugs: ☐ No ☐ Yes | Allergies: ☐ None ☐ Yes:

Current Medications: ☐ None ☐ Yes:

Any Prior Medical Conditions We Should Be Aware Of: ☐ None ☐ Yes
Listed:

Have You Had Any Of The Following Medical Conditions: ☐ None ☐ Pace Maker ☐ Take Coumadin ☐ Deep Vein Thrombosis | Any Surgical Procedures: ☐ None ☐ Yes Listed:

Any Medical Conditions Within The Family: ☐ None ☐ Yes: | Do You Exercise: ☐ Never ☐ Yes; How Often:

REVIEW OF SYSTEMS

Fever		Heart Burn		Joint Pain	
Chills		Abdominal Pain		Muscular Twitching/Cramps	
Fatigue		Nausea		Skin Rashes	
Sudden Weight Loss		Vomiting		Swollen Glands	
Breast Pain		Bowel Incontinence		Bruising	
Breast Lump		Shortness Of Breath		Bleeding Problems	
Palpitations		Cough		Headaches	
Chest Pain		Difficulty Urinating		Fainting	
Hot Flashes		Urgency/Frequency Urinating		Numbness	
Hearing Loss		Blood In Urine		Tingling	
Discharge Eyes/Nose/Ears		Urinary Incontinence		Panic Disorders	
Dizziness		Neck Pain		Depression	
Changes of Vision		Lower Back Pain		Anxiety	

Other:

Please Read and Sign:

The taking of a history and the conducting of a physical examination are not considered treatments, but are part of the process of gathering information to determine future care. I understand and agree that health and accident policies are an arrangement between any insurance carrier and myself. Furthermore, I understand that **Xin Quan Medical Rehabilitation and Acupuncture, PLLC** will prepare any necessary reports and forms to assist me in making a collection from the insurance. I authorize **Xin Quan Medical Rehabilitation and Acupuncture, PLLC** or the insurance company to release any information required to process my claims. I also authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balances for services rendered. If I suspend or terminate my care and treatment, all patient balances after the insurance payment will be due immediately and payable. If I choose to ignore my responsibility I agree to be liable to all collection and attorney fees if deemed necessary to recover the balance dues. This applies to Commercial, Self-Pay, HMO, Co-Pays, Medical Lien, and No-Fault Claims.

Patient Signature: _____ Date: _____

Guardian Signature: _____ Date: _____

ACKNOWLEDGEMENT OF RECEIPT

HIPPA NOTICE OF PRIVACY PRACTICES IS BEHIND THE REGISTRATION FORM. PLEASE READ, AND SIGN BELOW.

I have reviewed and/or received a copy of HIPPA Notice of Privacy Practices.

Patient Signature: _____ Date: _____