

33 Barker Avenue
 Professional Unit #2
 White Plains, NY 10601
 914-285-3480 (P)
 914-285-3479 (F)



REGISTRATION FORM

Please print out this form and bring to your appointment

PATIENT INFORMATION			
Last Name, First Name:		Phone #:	Marital Status: (1) Single (2) M (3) Div (4) Other
Do You Have Another Name? <input type="checkbox"/> No <input type="checkbox"/> Yes If Yes:	Social Security #:	Birth Date: / /	Gender: <input type="checkbox"/> M <input type="checkbox"/> F
Address:	City:	State:	Zip Code:
Occupation: <input type="checkbox"/> Retired	Who Referred You? <input type="checkbox"/> Friend: _____ <input type="checkbox"/> Other <input type="checkbox"/> Dr. _____ <input type="checkbox"/> 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: <input type="checkbox"/> Self		
Pt's Relation to Policy Holder : <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other	Date Of Birth of Policy Holder: / /	Social Security #:	
Secondary Insurance:	Policy Holder's Name: <input type="checkbox"/> Self		
Pt's Relation to Policy Holder : <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other	Date Of Birth of Policy Holder: / /	Social Security #:	
Tertiary Insurance:	Policy Holder's Name: <input type="checkbox"/> Self		
Pt's Relation to Policy Holder : <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other	Date Of Birth of Policy Holder: / /	Social Security #:	
WORKERS COMPENSATION/NO-FAULT			
Is this condition related to: <input type="checkbox"/> Work <input type="checkbox"/> Motor Vehicle Accident <input type="checkbox"/> Other		Date of Accident: / /	
Claim/Case #:	Adjuster's Name and #:		
Policy Holder's Name:			
Employer Name and #:			
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.

Please print and sign. Click here to print form

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: _____