SWAN ACUPUNCTURE VANCOUVER
311 W. Evergreen Blvd.
Vancouver, WA 98660
360-977-0020

Patient Information Form

Name: _____ Today's Date: _____

Address: _____
(Street, Apt #) (City) (State) (Zip)

E-mail address _____ Home Phone: _____ 0 Male 0 Female
Birthdate: _____/_____/_____ Age: _____
Employer & Address: _____ Work Phone: _____

Spouse or Parent: _____ Work Phone: _____

Address if different: _____

In Case of Emergency

Relative to contact (other than spouse) _____ Phone: _____
Relationship to Patient: _____ Cell: _____

Who referred you to our Clinic?

Person's or Dr's Name: _____ Phone Book _____ Other _____

Insurance Information

Primary Insurance: _____ Phone: _____

Name of Insured: _____ Birth Date of Insured: _____/_____/_____

Policy/ID# _____ Group # or Employer: _____

Relationship to Patient: _____

Name of responsible party (if different than insured) _____

Patient's or Authorized Person's Signature

As a service to our patients we will submit charges for medical treatment to our patient's insurance company. Therefore, your signature below authorizes the release of any medical or other information necessary to process your insurance claims which the insurance company may request concerning your present illness or injury with the exception of those test results which require specific authorization. You understand this office cannot accept responsibility for negotiating a settlement on a disputed claim. Some services provided are not covered by insurance to which I acknowledge I am financially responsible for all charges, and these will be paid at the time of service. Occasionally, even though coverage was verified before the medical services were provided, the insurance company may decline the claim. *Therefore, you also agree to be responsible for payment of services in the event your insurance company, Workers Compensation claim or attorney doesn't agree to pay for these services, or does not pay the claim in full.*

Signed:_____ Print Name:_____ Date: _____