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Santa Cruz Acupuncture
Orthopedics & Sports Medicine Clinic

WORKERS COMPENSATION PATIENT INFORMATION

Patient Name ______________________________ Age ____ DOB _______________ Sex ___

Address ______________________________ City _____________________ ZIP __________

Home Phone ______________________________ Work Phone ____________________________________

Cell Phone ______________________________ Email ____________________________________

Social Sec. # ______________________________

Please indicate below any ***preferences or restrictions*** *regarding phone calls/messages*:

- for appointment confirmation:____
- regarding medical or insurance information:____

Marital Status: □Married/Partnered □Single □Widow □Divorced □Separated

Current status: How long?

EMERGENCY CONTACT INFORMATION

Name ______________________________ Relationship ____________________________

Home Phone ______________________________ Work/mobile phone # ____________________________

TERMS OF ADMISSION TO CARE

Please check boxes and sign below to indicate that you have read and understood each section.

PATIENT INFORMATION

- □ I certify that the information given above by me is correct.
- □ I have received the *Notice of Privacy Practices* regarding my health information.
- □ I authorize the release of any information necessary to coordinate medical care and to secure payment for services rendered.

LATE CANCELLATIONS/MISSED APPOINTMENTS

- □ If you are unable to make a scheduled appointment, ***please call the office as soon as possible to avoid $35 late cancellation/missed visit charges.***
- □ ***More than three missed appointments without 24 hours prior notification may result in discharge from care, and further scheduling may not be allowed except at discretion of the practitioner.***

Signature ____ Date ________________________

(Interpreter) ____ Date ___________________________