Xue Clinic
Patient's Information

Today's Date ____________________

In order to serve you properly we will need the following information. (PLEASE PRINT) All information will be strictly confidential.

Patient's names: First ___________________M.I.___Last_____________________ Male □ Female □

Birth date: _____ /_______ /____________ marital status: married □ single □ divorced □ widowed □ other _______________

Residence address ____

City ____________________ State ______________ Zip ______________Email address: _____________________________________

Phone number: Home ____________________________ Work _______________________________ Cell ________________________

If patient is a child, parent or guardian's name ____

Driver's license number: ______________________________________Referred to our Clinic by _________________________________

Emergency Contact: Names_________________________________ Relationship ________________Phone _________________________

Employment Status: Full Time □ Part Time □ Retired □ Unemployed □ Student □

Occupation _________________________________
Employer's Name ____ Telephone # ____
Employer's Address ____

Spouse's Name _________________________________
Spouse's employer ____Telephone # ______________________________
Spouse's employer Address ____

Physician's Name ____Telephone # ______________________________
Physician's Address ____

Date of injury or Onset of illness ____

Account Paid By: Self □ Private Insurance □ Medi-Cal □ Worker's Comp. □ Other _________________________________

INSURANCE NFORMATION (Only some insurance company will cover acupuncture)
Primary Insurance ____Telephone # ______________________________________
Insurance Billing Address ____
Policy Holder's Name ____ Relationship _____________________________________
Policy #/ ID # ____ Group # ____

Secondary Insurance ____ Telephone # ______________________________________
Billing Address ____
Policy Holder's Name ____ Relationship _______________________________________
Policy #/ID # ____ Group #____

Insurance Responsibility Statement:
Having insurance is not a substitute for payment. Many companies have fixed allowances or percentages based on your contract with them, not with our clinic. It is your responsibility to pay the deductible, co-payment, and any other balances not paid by your insurance. We will assist you in billing your insurance company as much as possible. However, you are responsible for your bill.

Assignment and Release:
I hereby assign my insurance to be paid directly to the provider of service. I understand that I am financially responsible for any non-covered service. I also authorize the provider to release any information required to process any claims.

Signed ____ Date ____