

# EAST WEST INTEGRATIVE MEDICINE REGISTRATION

Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Telephone Number: \_\_\_\_\_ Mobile / Cellphone Number: \_\_\_\_\_  
Email: \_\_\_\_\_

**STATUS:** Single \_\_ Married \_\_ Widowed \_\_ Divorced \_\_ Separated \_\_ Minor \_\_  
Religious Affiliation (if any): \_\_\_\_\_

Patient's Employer / Name of School if Minor: \_\_\_\_\_ Occupation: \_\_\_\_\_  
Employer Address: \_\_\_\_\_ Work Phone Number: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Spouse's Employer (if minor Parent's) Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_  
Employer Address: \_\_\_\_\_ Work Phone Number: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

**Emergency Contact:** \_\_\_\_\_ Telephone Number: \_\_\_\_\_  
Relationship: \_\_\_\_\_ Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Referred by: \_\_\_\_\_ How did you hear about us? \_\_\_\_\_

## INSURANCE INFORMATION

Name of Insured: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Medical Record Number / Social Security Number: \_\_\_\_\_  
Date employed: \_\_\_\_\_ Name of Employer: \_\_\_\_\_  
Employer Telephone Number: \_\_\_\_\_  
Employer Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Insurance Carrier Name: \_\_\_\_\_ Policy Number: \_\_\_\_\_  
Address: \_\_\_\_\_ Group Number: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

*DO YOU HAVE ADDITIONAL INSURANCE?* YES \_\_ NO \_\_ If yes, complete the following:

Name of Insured: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Medical Record Number / Social Security Number: \_\_\_\_\_  
Date employed: \_\_\_\_\_ Name of Employer: \_\_\_\_\_  
Employer Telephone Number: \_\_\_\_\_  
Employer Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Insurance Carrier Name: \_\_\_\_\_ Policy Number: \_\_\_\_\_  
Address: \_\_\_\_\_ Group Number: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

I authorize the release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for health insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to the doctor.

Signature of Patient (or parent / guardian of minor) \_\_\_\_\_ Date: \_\_\_\_\_