



# Integrative Medicine Center

301 W. State St., Ithaca, NY 14850 Phone:(607)-275-9697 Fax:(607)-697-0153

## Patient Records

1. Name \_\_\_\_\_

**Last First MI**

2. Address \_\_\_\_\_

**P.O. Box or Street City State Zip Code**

3. Contact Number (\_\_\_\_\_) \_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_

**Home Work/Cell**

4. Birth Date \_\_\_\_\_ Age \_\_\_\_\_ Gender \_\_\_\_\_ 5. Employer \_\_\_\_\_

Occupation \_\_\_\_\_ 6. Social Security Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

7. To Notify in Case of Emergency \_\_\_\_\_

**Name Relationship**

Address \_\_\_\_\_

**P. O. Box or Street City State Zip Code**

Contact Number (\_\_\_\_\_) \_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_

**Home Work/Cell**

8. Reason For Visit \_\_\_\_\_

9. Allergies \_\_\_\_\_

10. Current Medication & Reason For Use \_\_\_\_\_

11. Brief Past Medical History & Surgeries \_\_\_\_\_

12. Do you have or have you ever had any of the following? (please circle) Yes No

(please circle all that apply) HIV positive AIDS Hepatitis

13. Are you a vegetarian? (please circle) Yes No If so, would you consider using animal products for medicinal purposes? (please circle) Yes No

14. How did you hear about our clinic? \_\_\_\_\_

15. Physician's Name \_\_\_\_\_ Office Number (\_\_\_\_\_) \_\_\_\_\_



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## CONSENT TO TREATMENT & FINANCIAL AGREEMENT

I, the undersigned, do affirm that I advise (print patient name) \_\_\_\_\_  
to consult a physician regarding the condition or conditions for which the patient  
seeks acupuncture and/or herbal treatment.

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SIGNATURE OF LICENSED ACUPUNCTURIST

DATE

I, the undersigned, do affirm that I, the patient, am seeking acupuncture and/or  
herbal treatment from Ann Y. Wang, a NYS licensed acupuncturist and a  
NCCAOM certified herbologist.

I, the undersigned, do understand that I am advised by Dr. Wang to consult a  
physician regarding the condition or conditions for which I, the patient, seek  
acupuncture treatment.

I, the undersigned, am financially responsible for payment of all medical services  
received at this office. I take responsibility for submitting any claims to my  
insurance provider should coverage apply for direct reimbursement. However, I  
authorize the provider, Ann Y. Wang, to release any information to my insurance  
provider should additional information be required to process my claim. I also  
know that any scheduled appointments are my responsibility and I will give at least  
24 hours prior notice for cancellation. Otherwise, I will pay the fees associated  
with any missed appointments.

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SIGNATURE OF PATIENT OR LEGAL GUARDIAN

DATE