Health Wise Acupuncture
761 Golf View Dr., Suite C
Medford, OR 97504
541.779.9393

Patient Information

Name:________________________________ Date of Birth:_____________

Address:____

City: ________________________________ State: __________ Zip Code: ______________________

Home Phone: _______________ Work Phone:________________ Cell Phone:_________________

Email:_______________________________________

Marital/Relationship Status:_________________ Emergency Contact:_____________________________

Relationship:_________________ Emergency Phone:____

Family Physician:____

Please take a moment to tell us how you came to this clinic:

Physician referral:___________________________ Personal referral:______________________________

Yellow Pages ☐ Print Advertising ☐ Informational presentation ☐

Other (please describe):____

Charges are due and payable at time of treatment unless confirmation of insurance coverage has been received. Insurance co-payments are due at the time of treatment. Appointments missed or canceled with less than 24 hours notice will incur the full regular cash charge. I have read the previous statement and I understand and agree to it.

Signature:____ Date:_____________

Insurance Information

Responsible Party:____________________________ Relation to Patient_____________________________

Address:____ Phone:_______________________

City:________________________ State:_______________________ Zip Code:____________________

Health Insurance Company:_____________________________________ Phone:_____________________

Address:____

City:________________________ State:_________________________ Zip Code:_________________

Subscribers Name:____________________________________ Effective Date:_______________________

Date of Birth:________________ Policy Number:________________ Group Number:_____________

I hereby assign Health Wise Associates LLC / Michael P. Pope, MS, LAc any medical benefits for services rendered by him to which I am entitled. I authorize the release of any medical or other information necessary to process claims for those services. I understand I am responsible for any charges not covered by my insurance.

Signature:____ Date:_____________