B. Well Acupuncture

4428 Ingraham St. San Diego, CA 92109 (619) 204-9966

Date: _____

Name: _____ Sex: o Male o Female

Address: _____

City: _____ State: _____ Zip: _____

Daytime Phone #: _____-_____-_____ Evening Phone #: ___-____-_____

Date of Birth: _____/_____/_____ Occupation: _____

Marital status: o Single o Married e-mail:_____

Primary Health Care Provider: _____

Provider's Address: _____

City:_____ State: _____ Zip: _____

Telephone #: _____-_____-_____ Extension: _____

Permission to Consult with Primary Provider? o No o Yes (please initial if yes)

In Case of Emergency, Please Notify:

Name: _____

Telephone #: _____-_____-_____

Relationship: _____

How did you hear about us: _____

Please list any previous surgeries, hospitalization, and serious illnesses with dates:

_____

_____

_____

What are the main symptoms/ailments you are seeking treatment for:

_____

_____

_____

Western Medical Diagnosis: Please check any diagnosis you have now or have had in the past:

_ Diabetes _ Peripheral Neuralgia _Stroke/Heart Attack _ Dementia
_ Multiple Sclerosis _ Fibromyalgia _ Pneumonia _ Candida
_ Chronic Fatigue _ Arthritis _ Carpal Tunnel _ Pacemaker
_ Shingles _ Epilepsy/Seizures _ Eating disorder _ Endocarditis
_ ADD _ STD_____ _ Asthma what Type:_____

_ Cancer what type:
_ Allergies: drugs/food/metal/oils/plants/pollen:
_____

Please indicate all symptoms below that you have experienced **within the past 30 days.**

Head, eyes, ears, nose, throat:

_ Sinus problems _ Nosebleeds _ Dry mouth _ Headaches
_ Thirst _ Thrush _ Sore throat/mouth _ Gum bleeding
_ Difficult swallowing _ Tinnitus _ Dizziness _ Vision Problems
_ Ear/hearing problem _ Sneezing/Runny nose

Respiratory:

_ Shortness of breath _ Pain w/deep breath _ Phlegm _ Blood in sputum _ Emphysema
_ Wheezing _ Frequent colds _ Cough _ Bronchitis

Gastrointestinal:

_ Loss of appetite _ Abdominal Cramps _ Nausea _ Diarrhea
_ Gas/Bloating _ Hiccups/Belching _ Constipation _ Vomiting
_ Heartburn _ Jaundice _ Hemorrhoids_ Sudden weight loss

Cardiovascular:

_ Low Blood pressure _ High blood pressure _ Palpitations _ Chest pain

Gentio-Urinary:

_ Frequent Urination _ Night Urination _ Impotence _ Low sex drive
_ Painful Urination _ BPH _ Genital sores _ Genital warts

Females only: Date of last period_____ # of pregnancies____ # of children_____

List any medications or supplements you are currently taking:

_____
_____
_____
_____

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Acknowledgement of receipt of notice of privacy practices

This notice summarizes how health data about you may be used and shared and how you can get access to this data. IMPORTANT NOTICE: This does not include all of the details about our privacy policy. For more details please ask for a copy of the NOTICE OF PRIVACY PRACTICES that we can provide you.

How we may use and share health data about you:

Treatment - to give you medical treatment or other types of health services

Payment - to bill you or a third party for payment for services provided to you

Health Care Operations - for our own operations such as quality control, compliance monitoring,

audit, etc.

Disclosures where we do not need your approval:

To you

As required by federal, state, or local law

If child abuse or neglect is suspected

Public health risks (for public health activities to prevent and control spread of disease)

Lawsuits and disputes (in response to a court or administrative order)

Law enforcement (to help law enforcement officials respond to criminal activities)

Coroners, medical examiners and funeral directors

Organ or tissue donation facilities if you are an organ donor

To avert a threat to an individual or public health safety

Disclosure where we need to get your approval:

Patient directories - You an decide what health data, if any, you want to be listed in patient directories. Persons involved in your case or payment for your care - We may share your health

data with a family member, a close friend, or other person that you have named as being involved with your health care.

Other uses of health data: Other uses not covered by this notice or the laws that apply to use will be made only with your written consent.

You have the following rights relating to the health data we keep about you:

Right to inspect your health record and receive a copy of your health record upon request

Right to amend information in your health record you believe is inaccurate or incomplete

Right to know to whom we have disclosed your health information

Right to ask for limits on the health information data we give out about you

Right to receive communication from us about your health information in alternate ways

Right to paper copy of the complete Notice of Privacy Practices

I acknowledge that I have read the NOTICE OF PRIVACY PRACTICES of this practice.

_____ _____

Signature of patient or representative Date

_____ _____

Print patient name Patient Date of Birth