

Alliance Wellness Center Inc./ Bend Community Acupuncture

740 NW Colorado Ave. Bend, OR 97701

Phone 541 388-4822 Fax 541 388-4805

New Patient Information

First name: _____ Last name: _____ Name you go by: _____

Address: _____ City: _____ State: ____ Zip: _____

Telephone: Day: _____ Evening: _____ Mobile: _____

For privacy reasons, which number(s) is it ok to leave a message at? Day: yes / no Eve: yes / no Mobile: yes / no

E-mail address: _____ Marital Status (circle) M S W D P (legally partnered)

Would you like to be notified about your appointment times via e-mail? yes / no

Would you like to be notified about upcoming events that AWC or BCA is associated with via e-mail? yes / no

Please note: YOUR E-MAIL AND CONTACT INFO IS PRIVATE, WE DO NOT SELL IT TO THIRD PARTIES.

Sex: Male Female Birth date: _____ Student: yes / no, If 'yes': full or part-time

Occupation: _____ Employer: _____

Emergency contact name: _____ Phone: _____ Relation: _____

Person who will be responsible for payment on this account: _____

Contact info for responsible party, (if different from patient's info above):

First name: _____ Last name: _____ Relationship to patient: _____

Address: _____ City: _____ State: ____ Zip: _____

Telephone: Day: _____ Evening: _____ Mobile: _____

Please complete the following important information.

Is your condition due to an accident? yes/ no If no, then what was the Date of onset? _____

If yes: Date of Accident: _____ State _____

Were you involved in an: automobile accident / work related accident / other _____ (Please circle one)

Do you have an open or ongoing insurance claim related to this accident? yes / no

How did you hear about us?: phone book / drive, walk, ride by / the Source / on the web / other _____

If you heard about us from a friend or as a referral from someone, please give us their name so we can thank them: _____

Have you had or are you currently having other acupuncture? yes / no If yes, where and when? _____