

Maureen McKenney, O.M.D.

Path To Wellness

acupuncture & herbal medicine

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CONFIDENTIAL HEALTHCARE QUESTIONNAIRE

PERSONAL INFORMATION (PLEASE PRINT)

NAME: _____ PATIENT S.S.# _____

BIRTH DATE: _____ AGE: _____

MARITAL STATUS ___ S ___ M ___ D ___ W NUMBER OF CHILDREN _____

HOME ADDRESS: _____

CITY, STATE, ZIP: _____

HOME PHONE: _____ WORK PHONE: _____ CELL PHONE: _____

(Please note which number you want to receive calls

about appointments or other health care information on) _____

EMPLOYER _____ OCCUPATION: _____

PERSON RESPONSIBLE FOR ACCOUNT: _____

RELATION TO YOU _____

INSURANCE CARRIER _____

FAMILY PHYSICIAN: _____ PHONE: _____

Have you ever been treated with acupuncture or Chinese medicine? ___ Y ___ N

Name of previous Acupuncturist? _____

EMERGENCY CONTACT _____ CONTACT PHONE: _____

WHOM MAY WE THANK FOR REFERRING YOU ? _____

CANCELLATION POLICY

PLEASE GIVE AT LEAST 24 HOURS NOTICE OF CANCELLATION, AT WHICH TIME WE CAN EASILY RESCHEDULE YOUR APPOINTMENT. YOU ARE EXPECTED TO PAY FOR THE TIME SET ASIDE FOR YOU IN THE CASE OF ANY MISSED APPOINTMENT, OR APPOINTMENT CANCELLED LESS THAN 24 HOURS IN ADVANCE.

I have read and understand my responsibility for payment of services.

SIGNATURE _____

DATE _____