Liying Acupuncture Healing Service, LLC.

REGISTRATION FORM

(Please Print)

Today's date:						

PATIENT INFORMATION

Patient's last name: First: Middle:			❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid	
Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F	
Street address:		Cell phone no.:		Home phone no.:		
City:	State:	ZIP Code:	Email:			
Occupation:	Employer:		Employer phone no.: ( )			
Chose clinic because/Referred to clinic by (please check one box):		❑ Dr.	❑ Insurance Plan	❑ Hospital		
❑ Family	❑ Friend	❑ Close to home/work	❑ YP.com	❑ Other		
Other family members seen here:						

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date: / /	Address (if different):		Home phone no.: ( )	
Is this person a patient here? ❑ Yes ❑ No					
Occupation:	Employer:	Employer address:		Employer phone no.: ( )	
Please indicate primary insurance	❑ BCBS	❑ UHC	❑ CIGNA	❑Carefirst	❑ BlueChoice
❑ VA Optum	❑ APWU	❑Carefirst FEP	❑ Cash	❑ Other	
Subscriber's name:	Subscriber's S.S. no. (VA):	Birth date: / /	Group no.:	Policy no.:	Co-payment: $
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other	
Name of secondary insurance (if applicable):	Subscriber's name:		Group no.:	Policy no.:	
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other	

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Liying Acupuncture Healing Service, LLC or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*