East-West Healing Arts Patient Registration Form
3000 Connticut Ave., NW Suite 139 Washington, DC 20008
Telephone/Fax: 202-483-7081

Name:____
(Last) (First) (Middle Initial)

Name of parent or guardian (if minor):____
(Last) (First) (Middle Initial)

Birth Date: ____/____/____ Age:____ Gender: □ Male □ Female

Marital Status: □ Never married □ Partnered □ Married □ Separated □ Divorced □ Widowed

Occupation: ______________________________________

Telephone #: (H)_____________________ (W)_____________________ (M)_____________________

Fax #: ___________________________Email:____

Current Address: ____

____

Emergency Contact: _________________________ Telephone #:____________________ Relationship:_______

Family Physician:: _________________________ Telephone #:____________________ Specialty:__________

Medical Insurance Carrier:____________________________________ Policy #:________________________

Supplemental Carrier:____ Policy #:________________________

Is this visit related to an injury, accident or illness which occurred at work? Y___N___. If yes…….

List date of injury: _______/____/______ Specify type of injury: _______________________________________

Employer: ______________________________W.Addr: _________________City________ST___ZIP________

Referred by:_____________________________Telephone #:_______________Relationship:________________

I acknowledge that I am personally responsible for payment of all services rendered.

Patient Signature: ____ Date: ____________
(If other than patient, list relationship)

Office Signature: ____ Date: ____________
(Witness)