Durango Acupuncture and Allergy Relief, Caleb Gates L.Ac. LLC
1199 Main Ave. Ste. 230, Durango, CO 81301; 970-259-9488

PATIENT INFORMATION

LEGAL NAME: LAST_____ FIRST/MIDDLE INITIAL_____

NAME YOU WISH TO BE CALLED_____ REFERRED BY: _____

If you're satisfied with your experience at the end of treatment are you okay with me asking you for a referral? ___YES___NO

DATE OF BIRTH_____ MALE_____ FEMALE_____ MARITAL STATUS_____

PHYSICAL ADDRESS_____ CITY, STATE, ZIP_____

MAILING ADDRESS_____ CITY, STATE, ZIP_____

CELL/ HOME PHONE_____ E-MAIL _____

WORK PHONE_____ EMPLOYER_____

SOCIAL SECURITY #_____ OCCUPATION_____

PATIENT'S PRIMARY CARE PHYSICIAN_____

RESPONSIBLE PARTY (PARENT/LEGAL GUARDIAN/LEGAL REPRESENTATIVE)

LAST NAME_____ FIRST NAME_____

MAILING ADDRESS_____ CITY, STATE, ZIP_____

HOME PHONE_____ WORK PHONE_____

RELATIONSHIP TO PATIENT_____

PERSON TO NOTIFY IN CASE OF AN EMERGENCY

LAST NAME_____ FIRST NAME_____

MAILING ADDRESS_____ CITY, STATE, ZIP_____

HOME PHONE_____ WORK PHONE_____

RELATIONSHIP TO PATIENT_____

INSURANCE INFORMATION / PERSON RESPONSIBLE FOR BILL (PROVIDE A CURRENT INSURANCE CARD AT TIME OF SERVICE)

INSURANCE COMPANY_____ ☐ **NO INSURANCE**

INSURANCE ID#_____ COPAY$_____ DEDUCTIBLE$_____

POLICY HOLDER: LAST NAME_____ FIRST NAME_____

MAILING ADDRESS_____ CITY, STATE, ZIP_____

DATE OF BIRTH_____ RELATIONSHIP TO PATIENT_____

EMPLOYEER_____ WORK PHONE_____

By signing this form, I verify that the information listed above is accurate and current to the best of my ability:

_____ _____
Signed by Patient / Legal Guardian / Legal Representative **Date**

I authorize payment of medical benefits to undersigned Physician or supplier for these services and all future claims:

_____ _____
Signed by Patient / Legal Guardian / Legal Representative **Date**