***AcuMeD Acupuncture&Herbs Clinic    (617) 393-1998***

***Patient Billing Information                    Date: ……/……/……***

First ________________________ Last………………………… MI _________

Address: ……………………… City _______________ State: ………. Zip:………
Tel (H)                              Tel(M) _____________________ Tel(W)……………

DOB:..…/……/……   MaritalStatus(circle-one):S   M   D   Other

Employed  Y   N              Employer _____________________________

FT/ PT Student?

**Insurance Informations:**

Insurance Plan / Program _______________________

Group ID Number ________________________ Policy Number: …………………………

Employer __________________________________ DOB _____/_____/……….
Last Name ______________________First.N ____________________ MI…………

Relation to Patient _________________ Phone ________________ Sex: M / F Other

St.______________________ City ____________ State _____ Zip______(If different)

Is There Another Insurance Plan? Y / N   Insurance Plan / Program ______________________

Group ID Number _______________        Policy Number _______________________

* Complete the following Only if applicable*

Is your injury related to:   **(Circle One)** Workman's' Comp Y / N Auto Accident Y / N

Attorney's Name _______________________ Phone: ………………………………..

Signature: ……………………………………………………….

**Office Use Only:****

Diagnosis Code(s):                 Date of Injury ____/_____/____