



GREAT WALL CHINESE MEDICINE

3337 N. Miller Rd., Ste 103, Scottsdale, AZ 85251

Tel: 4804298881 Fax: 4804298882 Website: www.chinesedrs.com E-mail: contact@chinesedrs.com

REGISTRATION FORM

Today's Date (M/D/YY):			
PATIENT INFORMATION			
Last name:	First:	Middle:	Social Security No.:
Birth date(M./D./YY):	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Marital status: <input type="checkbox"/> Single <input type="checkbox"/> Mar <input type="checkbox"/> Div <input type="checkbox"/> Sep <input type="checkbox"/> Wid	
Home phone: ()	Cell phone: ()	E-mail:	
Address:		City:	State: ZIP Code:
Of the above contact information, which is the most convenient way for us to confirm an appointment? <input type="checkbox"/> Home phone <input type="checkbox"/> Cell phone <input type="checkbox"/> E-mail			
Occupation:	Employer:	Employer phone: ()	
Find GWCM from:	<input type="checkbox"/> Search engine	<input type="checkbox"/> Insurance company	<input type="checkbox"/> Friends
<input type="checkbox"/> Close to home/work	<input type="checkbox"/> Yellow Pages	<input type="checkbox"/> Family member	<input type="checkbox"/> Dr.
<input type="checkbox"/> Others	Detail if info:		
INSURANCE INFORMATION			
Home Address (if different):		City:	State: ZIP Code:
Occupation:	Employer Name:	Work phone: ()	
Address:		City:	State: ZIP Code:
Is this patient covered by insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, name of the insurance company:	
Do you need us to help you summate the forms to insurance company? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Please indicate primary insurance	Provider phone: ()	Customer phone: ()	
Subscriber's name:	Subscriber's S.S. No.:	Birth date:	
Group No.:	Policy No.:	Co-payment: \$	
Patient's relationship to subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other			
Name of secondary insurance (if applicable):		Subscriber's name:	
Group No.:		Policy No.:	
Patient's relationship to subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other		Is this person a patient here? <input type="checkbox"/> Yes <input type="checkbox"/> No	
IN CASE OF EMERGENCY			
Name of local friend or relative (not living at same address):			
Address:		City:	State: ZIP Code:
Relationship to patient:	Home phone: ()	Work phone: ()	
Reasons for you visit here today: (List to right side)	1:	2:	
	3:	4:	
Would you like be testimonial when you feel better: <input type="checkbox"/> No <input type="checkbox"/> Yes and continue right side	TV: <input type="checkbox"/> Yes <input type="checkbox"/> No		Video or Audio: <input type="checkbox"/> Yes <input type="checkbox"/> No
	Latter post online: <input type="checkbox"/> Yes <input type="checkbox"/> No		
	Write review online: <input type="checkbox"/> Yes <input type="checkbox"/> No		



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HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential.

NAME (Last, First, M.I.):

Sex: M F

BIRTH DATE: (M/D/YY):

MARITAL STATUS:

Single Partnered Married Separated Divorced Widowed

PREVIOUS OR REFERRING DOCTOR:

DATE OF LAST PHYSICAL EXAM:

PERSONAL HEALTH HISTORY

CHILDHOOD ILLNESS:

Measles Mumps Rubella Chickenpox Rheumatic Fever Polio

Immunizations and dates (M. /D. /YY):

Tetanus

Pneumonia

Hepatitis

Chickenpox

Influenza

MMR *Measles, Mumps, Rubella*

LIST ANY MEDICAL PROBLEMS THAT OTHER DOCTORS HAVE DIAGNOSED

SURGERIES

Year

Reason

Hospital

Year

Reason

Hospital

OTHER HOSPITALIZATIONS

HAVE YOU EVER HAD A BLOOD TRANSFUSION?

Yes No

LIST YOUR PRESCRIBED DRUGS AND OVER-THE-COUNTER DRUGS, SUCH AS VITAMINS AND INHALERS

Name the Drug

Strength

Frequency Taken

ALLERGIES TO MEDICATIONS

Name the Drug

Reaction You Had

INFECTIONS DISEASE

HIV Hepatitis B Hepatitis C Flu Cold Streptococcus Mononucleosis Tuberculosis



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HEALTH HABITS AND PERSONAL SAFETY			
Exercise	<input type="checkbox"/> Sedentary (No exercise)		
	<input type="checkbox"/> Mild exercise (i.e., climb stairs, walk 3 blocks, golf)		
	<input type="checkbox"/> Occasional vigorous exercise (i.e., work or recreation, less than 4x /week for 30 min.)		
	<input type="checkbox"/> Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)		
Diet	Are you dieting?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	If yes, are you on a physician prescribed medical diet?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Rank salt intake	<input type="checkbox"/> Hi	<input type="checkbox"/> Med <input type="checkbox"/> Low
	Rank fat intake	<input type="checkbox"/> Hi	<input type="checkbox"/> Med <input type="checkbox"/> Low
Caffeine	<input type="checkbox"/> None <input type="checkbox"/> Coffee	<input type="checkbox"/> Tea	<input type="checkbox"/> Cola
	# Of cups/cans per day?		
Alcohol	Do you drink alcohol?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	If yes, what kind?		
	How many drinks per week?		
	Are you concerned about the amount you drink?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Have you considered stopping?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Have you ever experienced blackouts?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Are you prone to "binge" drinking?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Tobacco	Do you use tobacco?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	<input type="checkbox"/> Cigarettes – pks./day	<input type="checkbox"/> Chew - #/day	<input type="checkbox"/> Pipe - #/day
	<input type="checkbox"/> Cigars - #/day	<input type="checkbox"/> # of years	<input type="checkbox"/> Or year quit
Drugs	Do you currently use recreational or street drugs?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Have you ever given yourself street drugs with a needle?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Sex	Are you sexually active?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	If yes, are you trying for a pregnancy?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	If not trying for a pregnancy list contraceptive or barrier method used:		
	Any discomfort with intercourse?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Personal Safety	Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of this illness?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Do you live alone?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Do you have frequent falls?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Do you have vision or hearing loss?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Do you have an Advance Directive and/or Living Will?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Would you like information on the preparation of these?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Physical and/or mental abuse has also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider?		<input type="checkbox"/> Yes	<input type="checkbox"/> No



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FAMILY HEALTH HISTORY							
AGE		SIGNIFICANT HEALTH PROBLEMS		AGE		SIGNIFICANT HEALTH PROBLEMS	
FATHER				<i>Children</i>	<input type="checkbox"/> M <input type="checkbox"/> F		
MOTHER					<input type="checkbox"/> M <input type="checkbox"/> F		
<i>Sibling</i>	<input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/> M <input type="checkbox"/> F		
	<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> M <input type="checkbox"/> F			
	<input type="checkbox"/> M <input type="checkbox"/> F			GRANDMOTHER <i>Maternal</i>	<input type="checkbox"/> M <input type="checkbox"/> F		
	<input type="checkbox"/> M <input type="checkbox"/> F			GRANDFATHER <i>Maternal</i>	<input type="checkbox"/> M <input type="checkbox"/> F		
	<input type="checkbox"/> M <input type="checkbox"/> F			GRANDMOTHER <i>Paternal</i>	<input type="checkbox"/> M <input type="checkbox"/> F		
	<input type="checkbox"/> M <input type="checkbox"/> F			GRANDFATHER <i>Paternal</i>	<input type="checkbox"/> M <input type="checkbox"/> F		

MENTAL HEALTH		
Is stress a major problem for you?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you feel depressed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you panic when stressed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have problems with eating or your appetite?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you cry frequently?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever attempted suicide?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever seriously thought about hurting yourself?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have trouble sleeping?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever been to a counselor?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

WOMEN ONLY		
Age at onset of menstruation:	Date of last menstruation:	Period every days
Heavy periods, irregularity, spotting, pain, or discharge?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Number of pregnancies:	Number of live births:	
Are you pregnant or breastfeeding?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you had a D&C, hysterectomy, or Cesarean?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any urinary tract, bladder, or kidney infections within the last year?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any blood in your urine?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any problems with control of urination?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any hot flashes or sweating at night?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Experienced any recent breast tenderness, lumps, or nipple discharge?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Date of last pap and rectal exam?		



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MEN ONLY

Do you usually get up to urinate during the night?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, # of times		
Do you feel pain or burning with urination?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any blood in your urine?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you feel burning discharge from penis?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Has the force of your urination decreased?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you had any kidney, bladder, or prostate infections within the last 12 months?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have any problems emptying your bladder completely?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any difficulty with erection or ejaculation?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any testicle pain or swelling?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Date of last prostate and rectal exam?		

OTHER PROBLEMS

Check if you have, or have had any symptoms in the following areas to a significant degree and briefly explain.

<input type="checkbox"/> Skin	<input type="checkbox"/> Chest/Heart	<input type="checkbox"/> Recent changes in:
<input type="checkbox"/> Head/Neck	<input type="checkbox"/> Back	<input type="checkbox"/> Weight
<input type="checkbox"/> Ears	<input type="checkbox"/> Intestinal	<input type="checkbox"/> Energy level
<input type="checkbox"/> Nose	<input type="checkbox"/> Bladder	<input type="checkbox"/> Ability to sleep
<input type="checkbox"/> Throat	<input type="checkbox"/> Bowel	<input type="checkbox"/> Other pain/discomfort:
<input type="checkbox"/> Lungs	<input type="checkbox"/> Circulation	<input type="checkbox"/> Other

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the provider. I understand that I am financially responsible for any balance. I also authorize GWCM or insurance company to release any information required processing my claims.

Patient/Guardian signature or Legal Guardian Signature:

Print (Last, First):

Date:

HIPAA Privacy Authorization Form

Authorization for Use or Disclosure of Protected Health Information
(Required by the Health Insurance Portability and Accountability Act – 45 CFR Parts 160 and 164)

1. I hereby authorize _____ to use and/or disclose the
[Name of Health Care Provider]
protected health information described below to _____.
[Name of Individual]

2. Authorization for Release of Information. Covering the period of health care from
 _____ to _____ **OR** all past, present and future periods:

a. I hereby **authorize the release of my complete health record** (including records relating to mental health care, communicable diseases, HIV or AIDS, and treatment of alcohol/drug abuse).

OR

b. I hereby **authorize the release of my complete health record with the exception of the following information:**

Mental health records

Communicable diseases (including HIV and AIDS)

Alcohol/drug abuse treatment

Other (please specify): _____

3. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

4. This authorization shall be in force and effect until _____, at which time this
authorization expires. [Date or Event]

5. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

6. I understand that my treatment, payment, enrollment or eligibility for benefits will not be conditioned on whether I sign this authorization.

7. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Signature of Patient or Personal Representative

Date

Print Name of Patient or Personal Representative

Relationship to Patient



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INFORMED CONSENT AND DISCLOSURE

Informed Consent:

I hereby request and consent to acupuncture treatment and/or herbal supplement recommendations for me (or my legal charge) provided by Great Wall Chinese Medicine (GWCM). I understand that GWCM will explain all known risks and complications, and I wish to rely on GWCM to exercise judgment during the course of the procedure, which GWCM determines is in my best interests. I may request another person of my choice to be present in the treatment room during the treatment.

GWCM has discussed with me the procedures listed below that may be used in my treatment. I have read the information below and understand the possible risk involved. I agree to GWCM's use of this treatment (*if indicated*).

- **Acupuncture** is a safe and effective method of treatment. However, it can occasionally cause slight bleeding that usually resolves with pressing dry cotton on the spot where the skin is bleeding. It is also normal for the patient to have a temporary warm, tight, sore or tingling sensation at the acupuncture site.
- **Acupressure/TuiNa** involves rubbing, kneading, pressing, and stroking, etc., which may result in muscle soreness at the massage site that can last several days. This technique may require disrobing. I understand all attempts will be made to assure my privacy.
- **Indirect Moxibustion** requires burning an herbal material near the skin or on an acupuncture needle. Every precaution is taken to prevent skin contact, but the possibility of skin contact and mild burns exists. Great Wall Chinese Medicine does not allow direct moxibustion where material contacts the skin.
- **Cupping** involves a localized suction produced by heating a small glass cup. There is a possibility of local bruising from the suction and slight burning or blistering due to the heat involved in the technique.
- **Gua Sha** involves scraping over a small area by using a smooth-edged instrument. There is a possibility that local bruising is likely to occur at the site where Gua Sha is performed.
- **Tapping, Plum Blossom, Bleeding, Pricking** all involve multiple needle pricks at a localized site. Slight bleeding and/or bruising at the treatment site are a likely occurrence. Only single-use needles are used in these procedures.
- **Electrical Stimulation/TENS** uses micro current electricity to stimulate acupuncture points. A mild tingling sensation of electricity will be felt.
- **Infrared** involves utilizing infrared radiation. It is a safe and medically proven method of healing.

I have read, or have had read to me, the above consent, and have had the opportunity to ask questions and discuss this with GWCM. I consent to the treatment that involves the above procedures for my present condition(s) and any future conditions. I have the right to refuse or discontinue any treatment at any time and understand that this refusal may affect the expected results.

Authorization for Release of Medical Information:

I further understand that GWCM may need to contact my medical physician if and when they have identified that my condition needs to be co-managed with my medical doctors. The conditions that may require co-management include but are not limited to; pregnancy related nausea, pain associated with Multiple Sclerosis, neuromusculoskeletal effects of stroke, pain/nausea related to cancer/tumor, chemotherapy related nausea, Pain/nausea related to AIDS/ARC, pain or nausea related to surgery. This coordination of care intends to manage my health condition in my best interest and assure the optimal outcome of my acupuncture treatments. Therefore, I give my authorization to GWCM to contact my medical physician if/when necessary.

Treatment of Pediatric Patients <3 years:

I understand that treatment of young children has some risk and should be coordinated with the child's physician. If I am signing for my child under the age of eighteen (18), I give my authorization to GWCM to contact my child's medical doctor if/when necessary.

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 GWCM or insurance company to release any information required processing my claims.

Patient/Guardian Signature or Legal Guardian Signature

Print (Last, First)

Date:



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PAYMENT POLICY and AGREEMENT

Patient's Understanding and Responsibility of Payment for Treatments:

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I clearly understand that any amount of all services rendered to me is charged directly to me and that I am personally responsible for payment. However, for services covered by my insurance, I understand that GWCM will prepare any necessary reports and forms to assist me in collecting from the insurance company and any amount authorized to be paid directly to GWCM will be credited to my account upon receipt.

Insurance Coverage and Insurance Billing:

Upon my initial visit, GWCM will review with me my insurance, insurance coverage and out-of-pocket payment (such as fixed-amount COPAY per my covered insurance policy.) GWCM will also review with me their various discounted payment plans for quantity pre-payments.

I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in-full and immediately upon presentation of the appropriate statement. I understand and agree that full payment, paid in cash, check, or credit card, is required at time services rendered if my insurance does NOT cover the services rendered.

I understand that GWCM does accept patients who have NO insurance if they are financially capable and responsible for payments in-full either in cash, check, or credit card at the time services are rendered.

Assignment of Insurance Payment Benefits:

I hereby authorize and direct my insurance carrier, including private insurance and any other health/medical plan, to issue payment check(s) directly to Great Wall Chinese Medicine for services rendered to myself and/or my dependents. I understand that I am responsible for any amount not covered by insurance.

Authorization to Release Information:

I hereby authorize Great Wall Chinese Medicine to: 1.) Release any information necessary to insurance carriers regarding my illness and treatments; 2.) Process insurance claims generated in the course of examination or treatment; and 3.) Allow a photocopy of my signature to be used to process insurance claims. This authorization will remain in effect until revoked by me in writing. I have requested services from Great Wall Chinese Medicine on behalf of myself and/or my dependents, and understand that by making this request that I become fully responsible for any and all charges incurred in the course of the treatment authorized. I understand that I will be responsible for any court costs or collection fees should it become necessary for GWCM to take action for services/supplies rendered.

I have read, understand, and agree to Great Wall Chinese Medicine's **PAYMENT POLICY and AGREEMENT.**

Patient/Responsible Party Signature

Print (Last, First)

Relationship to Patient

Date