FIVE BRANCHES UNIVERSITY **ZENITH MEDICAL GROUP LLC**

Clinic of Traditional Chinese Medicine ***DBA TCM Clinic***

Santa Cruz:
200 Seventh Ave, Ste. 115, Santa Cruz, CA 95062
PH: (831) 476-8211 Fax: (831) 476-8088

San Jose:
1885 Lundy Ave, Suite 108, San Jose, CA 95131
PH: (408) 260-8868 Fax: (408) 260-8889

Welcome to the Five Branches University/Zenith Medical Group TCM Clinic. To help us provide you with the best possible care, please fill out this form as accurately as possible ***using Black Ink ONLY please****. All the information will be kept confidential.*

Name:_____
First Middle Last

Address:_____
Street City State zip code

Home Phone: (_____) _____ Work or Cell Phone: (_____)_____
Please circle one

Birth Date: _____/_____/_____ Age: _____ E-Mail: _____
MM DD YY *We do not share email addresses with any outside parties.*

Marital Status: _____ Gender: _____ Occupation: _____

In case of emergency, contact: _____ _____ _____
Name Relationship Telephone

How did you hear about us? _____

Do you have Medi-Cal? □ Yes □ No (Central California Alliance *only*)

Do you have Private Insurance? □ Yes □ No If yes, please fill out Insurance Verification Form

Office Policy:

All fees for medical services are due at the time of visit unless arrangements have been made between Five Branches/Zenith Medical Group and your insurance company. Five Branches /Zenith Medical Group TCM Clinic will bill for insurances that cover Acupuncture/TCM. I understand that I am fully responsible for my bill and that if attempts to collect payment from my insurance company/responsible party are not successful, I will remit the balance due in full upon notification. Please note that all published prices reflect a courtesy discount for cash patients.

Cancellation Policy:

If you need to cancel an appointment, please give us a minimum of 24 hours notice. We assess a cancellation fee for less than 24 hour notification.

◆ My signature authorizes the Five Branches University/Zenith Medical Group TCM Clinic to treat me (or the patient for whom I am legally responsible) with acupuncture and Chinese medicinal herbs within the licensure granted by the Medical Quality Assurance Board of the State of California and the California Acupuncture Committee.

◆ I do not expect the acupuncturist to be able to anticipate and explain all risks and complications, and I wish to rely on the acupuncturist to exercise judgment during the course of the procedure, which the acupuncturist feels based upon the facts then known, is in my best interests.

◆ I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

◆ I authorize the release of any medical or other information necessary for insurance claim processing and I understand that my individually identifiable medical information will be used only as necessary for purposes of treatment, payment, and other healthcare operations.

◆ I have received the Five Branches University/Zenith Medical Group TCM Clinic Notice of Privacy Policies.

Signature: _____ Date: _____
(Patient, Parent or Guardian)

Medical History: Check all boxes below that are now or have been part of your personal health history.

	Current	Past		Current	Past		Current	Past
Arthritis	❑	❑	Chronic Fatigue	❑	❑	HIV +	❑	❑
Abortion	❑	❑	Diabetes	❑	❑	Hypoglycemia	❑	❑
Allergies *(specify)* _____	❑	❑	*(specify)* _____			Injuries	❑	❑
			Digestive Disorders	❑	❑	Implants *(specify)*_____	❑	❑
Anemia	❑	❑	Emphysema	❑	❑	Irregular Pregnancy	❑	❑
Asthma	❑	❑	Epilepsy	❑	❑			
Bleeding Tendency	❑	❑	Headaches	❑	❑	Psychological Disorders	❑	❑
Blood Pressure	❑	❑	Heart Disease	❑	❑	Surgery	❑	❑
Circle one: High Low			Hepatitis	❑	❑	Vaginal Infections	❑	❑
Bronchitis	❑	❑	***(Specify Type)*** A___ B___ C___			Thyroid	❑	❑
Cancer *(specify)* _____	❑	❑	Heavy Bleeding	❑	❑	Other:_____		

Chief Complaint: Please describe your chief health concerns and other relevant information not mentioned above.

Are you being treated elsewhere? □ Yes □ No

For what complaint? _____

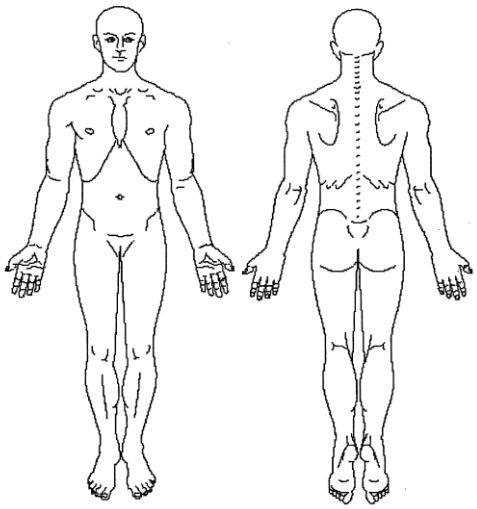
Personal Physician:_____
Name

Are you currently using prescription or herbal medicines? □ Yes □ No
If yes, please list: _____

Lifestyle: Which of the following is/are part of your lifestyle?

❑ Tobacco Smoking	❑ Recreational Drugs	❑ Exercise
❑ Coffee Drinking	❑ Birth Control Pills	❑ Relaxation/Meditation
❑ Alcohol Drinking	❑ Vitamins/Supplements	❑ Special Diet specify below:

Please indicate with an X any areas of pain or injury:



❑ Sudden Onset vs □ ❑ Gradual Onset
❑ Constant vs ❑ Intermittent
❑ Sharp vs ❑ Dull

❑ Spasms/Tremor ❑ Stiffness
❑ Numbness ❑ Tingling
❑ Swelling/Edema ❑ Burning
❑ Bruising/Tenderness ❑ Radiating to_____