GALE-HACIENDA MEDICAL CENTER

Dr.Zhang Acupuncture & Herbs Clinic

15574 E. Gale Ave., Hacienda Heights, CA 91745 Tel 626-961-9596; Fax 626-961-8594
14785 Jeffrey Rd., Suite 212, Irvine, CA 92618 Tel 949-748-0201; Fax 949-733-3010

INSURANCE VERIFICATION FORM

Please call your insurance company and complete this form by asking the following questions.

Patient name:_____

Date of call:_____ Time:_____ Spoke to:_____

Insurance Co_____ Phone #: (_____)_____

Insured:_____ Relation to Patient:_____

Policy #:_____Group #:_____

1. Is Acupuncture covered on this plan? o Yes / o No
2. Is a referral required from my Primary Care Physician? o Yes / o No
3. Is pre-authorization required? o Yes / o No
4. Am I limited to specific diagnosis codes? o Yes / o No
   (If yes, does one of these codes apply to your illness? o Yes / o No)
   (If no, stop here)
5. Is there a deductible? o Yes / o No
   If yes, what is the deductible? $_____
   How much has been met? $_____
6. Is there a maximum yearly benefit for Acupuncture? o Yes / o No
   Is that per o calendar year / o fiscal year / o renewal date?
   _____# of visits per year. _____# of visits used year to date.
   $_____ of Acupuncture care per year. $_____used year to date.
7. What percentage is covered? _____%
8. Is there a co-payment or leftover percentage that I am responsible for?
   o Yes / o No If yes, what is it? $_____
9. Does my plan cover herbal prescriptions? o Yes / o No
10. Are benefits for other forms of alternative health care (Chiropractic, Massage, Naturopathic) taken from the same pool as Acupuncture?
    o Yes / o No

Claims Address:_____

City:_____ State:_____ Zip:_____

Please note, benefits stated by a representative cannot be guaranteed.

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ACUPUNCTURE AND ORIENTAL MEDICINE
INFORMED CONSENT FOR TREATMENT

I, _____, hereby authorize the private practitioners of Wedgwood Acupuncture and Botanical Medicine to perform the following specific procedures as necessary to facilitate my diagnosis and treatment:

Acupuncture: insertion of special sterilized needles through the skin into underlying tissues at specific points on the surface of the body.

Cupping: a technique used to relieve symptoms in which cups made of glass or other materials are placed on the skin with a vacuum created by heat or other device.

Gua Sha: rubbing on an area of the body with a blunt, round instrument.

Heating Lamp or Pad: produces heat on the acupoints or meridian areas to relieve symptoms.

Laser Acupuncture: use of laser light on acupoints and meridians.

Electrical Acupuncture: use of electrical device to produce electrical stimulation on the acupuncture needles.

Herbs: may be given in the form of pills, powders, tinctures, pastes, plasters, or other forms such as raw herbs to be cooked. Cooked herbs may be given to take internally or externally as a wash. Herbal formulas may include shell, mineral, and animal materials.

Moxa: indirect burning on an acupoint using stick, string, or ball moxa to relieve symptoms.

Tuina: an ancient massage used to treat a wide variety of common disharmonies.

Dietary Advice: based on traditional Chinese Medical Theory.

I recognize the potential risks and benefits of these procedures as described below:

Potential risks: discomfort, pain, infection, or blistering at the site of the procedure; temporary discoloration of the skin; nausea, loose bowel movements, abdominal cramping; and aggravation of the symptoms prior to the acupuncture treatment.

Potential Benefits: drugless relief of presenting symptoms and improved balance of bodily energies, which may lead to prevention or elimination of the presenting problem and the strengthening of the constitution.

Notice to Pregnant Women: We do not use labor stimulating acupuncture points unless the treatment is specifically for the induction of labor. A treatment intended to induce labor requires a letter from a primary care provider authorizing or recommending such a treatment. All female patients must alert the doctor if they know or suspect that they are pregnant.

With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by Wedgwood Acupuncture and Botanical Medicine or any of its personnel regarding cure or improvement of my condition. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

I understand that Gale-Hacienda Medical Center may have a precept student for observation only. I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others unless so directed by myself or my representative or if it is required by law. I understand that I may look at my medical record at any time and can request a copy of it by paying the appropriate fee. I understand that my medical record will be kept for a minimum of three, but no more than ten years after the date of my last treatment.

_____ _____

Date Signature of Patient, Patient Representative or Guardian

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PATIENT INFORMATION

NAME:	DATE OF BIRTH:
HOME PHONE: OK to Call? Yes ( ) No ( ) Emergency Only ( )	WORK PHONE: OK to call? Yes ( ) No ( ) Emergency Only ( )
HOME ADDRESS: NUMBER & ST CITY, STATE & ZIP	PLACE OF BUSINESS: POSITION HELD SOCIAL SECURITY #:
PERSON TO CONTACT IN EMERGENCY:	RELATIONSHIP TO PATIENT:
COMPLETE ADDRESS OF ABOVE PERSON:	HOME PHONE: WORK PHONE:
REFERRED BY:	RELATIONSHIP TO PATIENT:

INSURANCE INFORMATION

INSURANCE COMPANY NAME:	GROUP NUMBER:
SUBSCRIBER:	SUBSCRIBER ID#
Is your condition related to work, injury, or auto accident? (Specify)	

FINANCIAL AGREEMENT & AUTHORIZATION FOR TREATMENT

I, the undersigned, have insurance coverage with (name of the insurance company or write "none" if uninsured) _____ and assign directly to Gale-Hacienda Medical Center all medical benefits, if any, otherwise payable to me for services rendered. **I understand that I am financially responsible for all charges whether or not paid by insurance**. I hereby authorize your clinic to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

Signature of Insured/Guardian/Patient _____Date _____

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PATIENT HISTORY QUESTIONAIRE

PERSONAL INFORMATION

Name:			Date:
Sex:	Age:	Date of Birth:	Place of Birth:
Height:		Weight:	Occupation:
Relationships: [ ] Married [ ] Divorced/separated [ ] Widowed [ ] Single [ ] Cohabitating [ ] Homosexual/Bisexual			
Regular Health Provider:		Specialty:	Phone:
Date of Last Medical Care:		Reason:	
Diagnosis of Problem: (If available)		May we contact your health care provider concerning your records? Yes [ ] No [ ]	
Referred to this office by : Dr. [ ] Friend [ ] Internet [ ] Yellow pages [ ] Ads [ ] Others [ ]			

Yes [ ] No [ ] Have you had an acupuncture treatment before?
Yes [ ] No [ ] Are you nervous about needles?
Yes [ ] No [ ] Do you have a tendency to faint?
Yes [ ] No [ ] Do you bleed for a long time or bruise easily?
Yes [ ] No [ ] Are you extremely hungry at the present time?
Yes [ ] No [ ] Are you extremely tired right now?
Yes [ ] No [ ] Do you have diabetes?
Yes [ ] No [ ] Do you have hepatitis or AIDS?
Yes [ ] No [ ] Have you ever had hepatitis?
Yes [ ] No [ ] Do you have a pacemaker?
Yes [ ] No [ ] Are you taking any medications now?
Yes [ ] No [ ] Are you undergoing any other treatment therapies now?
Yes [ ] No [ ] Women - are you pregnant?

PRESENT HEALTH

What do you consider to be your most important health problem?
Reason for today's visit? (Specify)

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FAMILY HISTORY

Has any blood relative had any of the following? Cancer o Allergies o TB o Diabetes o Stroke o Hypertension o Heart Disease o Thyroid Disease o Other	General state of health/age of your parents & siblings: (If deceased, state cause)

MEDICAL HISTORY

Past major illnesses:	Major accidents, falls, etc. :
Hospitalizations/surgeries/radiation treatments:	Location of all major scars:
Allergies to drugs, chemicals, foods, environment:	

REVIEW OF SYSTEM

If you are having any of the following problems at this time, please place a check on the line in front of it. Also, fill in the blanks where indicated.

General Condition

o Fever	o Weight loss	o Swollen glands	o Night sweats
o Weight gain	o Strong thirst (cold or hot drink)		o Sweat easily
o Chills	o Hot soles & palms	o Feelings of cold	o Feelings of heat
o HIV (+) or AIDS	o Easily fatigued	o Energy drop at _____ (time of day)	

Skin and hair

o Bruise easily	o Rashes	o Hives	o Pimples
o Itching	o Dry skin or hair	o Oil skin or hair	o Loss of hair
o Recent moles	o Abnormal growths	o Sores or wounds do not heal	

Head, Eyes, Ears, Nose, and Throat

o Headaches	o Migraines	o Dizziness or vertigo	o Poor vision
o Cataracts	o Eye pain	o Spots in eyes	o Night blindness
o Color blindness	o Blurry vision	o Ringing in ears	o Poor hearing
o Nose bleeds	o Nasal stuffiness	o Loss of smell	o Bleeding gums
o Dry throat/mouth	o Lots of saliva	o Persistent hoarseness	o Jaw clicks
o Gum problems	o Grind teeth	o Other	

Neuropsychological system

o Seizures	o Poor memory	o Frequent headaches	o Concussion
o Easily stressed	o Depression	o Anxiety/ fear	o Bad temper
o Crying spells	o Overwhelming joy	o Treated for mental problem	
o Don't know how to relieve stress			

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Cardiovascular System

o High blood pressure	o Low blood pressure	o Chest pain & tightness	o Fast heartbeat
o Slow heartbeat	o Iregular heartbeat	o Fainting	o Swelling in limbs
o Leg pain when walk	o Leg vein trouble	o Bleeding disorder	o High cholesterol

Pulmonary System

o Cough	o Asthma	o Tight chest	o Coughing with blood
o Shortness of breath	o Bronchitis	o Frequent catching colds & flu	o Color of sputum _____

Gastrointestinal System

o Poor appetite	o Trouble swallowing	o Nausea	o Vomiting
o Belching	o Bad breath	o Bloated after meals	o Acid reflex
o Gas/cramping	o Loose stools	o Bloody stools	o Black stools
o Rectal pain	o Hemorrhoids	o Bowel movements frequency _____ times.	

Hepatic and Billiard System

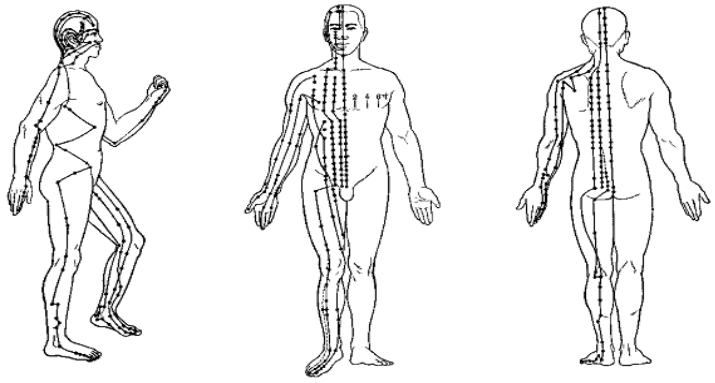
o Hepatitis	o Jaundice	o Hypochondriac pain	o Gall stone
o Cholecystitis	o Cirrhosis	o Ascites	o Liver enlargement

Genitourinary System

o Painful urination	o Burning urination	o Difficulty urinating	o Urgent need to urinate
o Blood in urine	o Kidney stones	o Urine scanty and dark	o Edema
o Frequent urination	o Incontinence	o STD	o Prostate trouble
o Discharge from penis	o Impotence	o Wake up to urinate at night _____times.	

Musculoskeletal System

o Joint pain/ stiffness	o Neck pain	o Muscle pain	o Upper back pain
o Localized weakness	o Lower back pain	o Numbness/ tingling	o Leg pain
o Pain interferes with normal daily activities		o Locations of problems (list below)	



Pregnancy/Gynecological System

o Vaginal discharge	o Vaginal sores	o Breast lumps	o Nipple discharge
o Are you pregnant now?	o Menopause	o PMS	o Fibroid
# of pregnancies _____	# of births _____	# stillborn/abortions ____	Birth control type_____
Last PAP smear _____	Last menses_____	Period: Every ____ days	Lasts _____days

Please circle one in each category below:

Cycle: o Regular or o Irregular — Flow: o Excessive, o Scanty, o Normal

Blood: o Dark Red, o Bright Red ,or o Pale Red — Clots present: o Yes o No

Cramping: o Yes o No, If yes, pain is o Before, o During, or o After the period.

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