TARRA ACUPUNCTURE

907 Irwin Street, San Rafael, CA 94901 · 510.409.0145

Patient Registration

Please fill out completely

Patient Name:_____ MI:_____ Last:_____

Street Address:_____

City:_____ State:_____ Zip:_____ Gender: M / F

Home PH:_____ Work PH:_____ Cell PH:_____

Date of Birth:___/___/___ Age:_____ E-Mail:_____

Employer:_____

Employment: ( )Employed ( )Unemployed ( )Student ( )Retired

Marital Status: ( )Single ( )Married ( )Divorced ( )Widowed ( )Other

Referred By:_____

In case of emergency contact:_____

Relationship:_____ Phone:_____

Primary Insurance

Insurance Company Name:_____ Phone:(_____)

Claims Address:_____

City:_____ State:_____ Zip:_____

Subscriber's Name:_____ Date of Birth:___/___/___

Relationship to you: ( )Self ( )Spouse ( )Parent ( )Other

I.D./Claim# as shown on card:_____ Group/Policy #:_____

Employer:_____

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Patient Registration (Continued)

Secondary Insurance or Auto/L&I

Is this visit injury related? ( )Y ( )N Work related? ( )Y ( )N

Auto Accident? ( )Y ( )N State:

Insurance Company Name: Phone:( )

Claims Address:

City: State: Zip:

Subscriber's Name: Date of Birth: / /

Relationship to you: ( )Self ( )Spouse ( )Parent ( )Other

I.D./Claim# as shown on card: Employer if applicable:

Group/Policy #:

I understand that I am financially responsible for all charges and agree to pay for services. I authorize the doctor to release to my insurance companies any and all information necessary to process my claims. I further authorize that payment be made directly to the physician.

Signature: **Date:**

_____ _____