Authentic Acupuncture

Peter Sheng, M.D.

PATIENT	SPOUSE/GUARANTOR
NAME	NAME
ADDRESS	ADDRESS
HOME PHONE ()-	HOME PHONE ()-
CELL PHONE ()-	CELL PHONE ()-
BIRTHDATE	BIRTHDATE
EMPLOYER	EMPLOYER
WORK PHONE	WORK PHONE
OCCUPATION	OCCUPATION
MARITAL STATUSMARRIEDSINGLE	DIVORCEDWIDOWED
SEXFEMALEMALE	
EMERICAL CONTRACT	
EMERGENCY CONTACT	RELATIONSHIP PHONE NUMBER
REFERRING PHYSICIAN	PHONE
PRIMARY PHYSICIAN	PHONE
	EASE OF MEDICAL INFORMATION FAMILY MEMBERS
I HEREBY CONSENT TO THE RELEASE OF MY TREATMENT PLAN, TEST RESULTS AND ANY MEDICAL INFORMATION TO UP TO TWO FAMILY MEMBERS:	
Contact #1	
Name	Relationship Phone number
Contact #2	
Name	Relationship Phone number
ACUPUNCTURE F	FINANCIAL GUARANTEE
patient's responsibility to pay at time of service. This office w	puncture treatments and herbs prescribed by Dr. Sheng. It is the will provide proof of treatments for patients if needed. I stal amount due at time of treatment. A \$15.00 charge will be assessed
Signature of responsible party Dat	te Relationship to Patient