Jill Nahama, L.Ac., O.M.D.

PERSONAL INFORMATION: Date: ______________

Name: ____

Sex: Female ________ Male ________ Age: _________ Date of Birth: ______________

Home address: ____

City: ______________________________ State & Zip: ______________________

Home phone: ________________________ Work phone: ______________________

Cell phone: _________________________ Email: __________________________

Occupation: ______________________ Who referred you to the office? ____________________

MEDICAL HISTORY

Please describe your current health complaints, both medical and psychological. List any known food or environmental allergies and your reaction to them.

1. ____

2. ____

3. ____

4. ____

5. ____

INSURANCE – INFORMATION & AUTHORIZATION

Name of company: ______________________ I.D. No.: ______________________

Insurer's phone: ______________________

I ______________________________ , ______________________________

(Please print your name) (Please sign your name)

authorize the release of my medical records to my insurance company. I also assign my insurance benefits to be paid directly to Jill Nahama, L.Ac., O.M.D.

MISSED APPOINTMENTS

In the event you need to cancel an appointment, it will be necessary for you to notify the office 24 hours prior to the scheduled appointment time. If notice is not received within that time frame and we are unable to fill your time slot, there will be a $65.00 charge.

THE UNDERSIGNED ACCEPTS FULL RESPONSIBILITY FOR ALL TREATMENT CHARGES:

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Signature

Please list all medications/supplements you are currently taking:

Medications/supplements: Purpose:

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