

Longevity Acupuncture & Oriental Medicine

Melissa Crum, D.O.M.
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Patient Information:

Name: _____

Address: _____

City, State, Zip: _____

Home phone: _____ **Work phone:** _____

Cell Phone: _____ **E-Mail address:** _____

Employer: _____

Date of birth: _____ **Insurance Carrier:** _____

Policy #: _____

Emergency Contact: _____

Main Complaint: _____

Other complaints: _____

Females – Last menstrual period: _____

Is there any chance that you could be pregnant? _____

Current medications(including herbs and vitamins):

Is there anything that I should know in order to provide better care?

Past Surgical History/Significant Past Medical History:

Any food allergies, drug allergies or sensitivities:

I authorize Dr. Melissa Crum, D.O.M. to release any and all medical records to my insurance company. This authority to release includes but is not limited to: diagnosis/prognosis, diagnostic tests, hospital reports and test results, x-rays, etc. as needed by authorized agents of the insurance company.

I understand that I am responsible for full payment for services rendered by Longevity Acupuncture and Melissa Crum. In the event that my insurance does not cover services rendered, I will be personally responsible for payment.

Releasor signature

Date

Releasor Name (print) _____

Witness _____