

TAO OF WELLNESS

PATIENT INFORMATION:

Name: _____
Last Name First Name

Age _____ Date of Birth: ____/____/____ Driver's License #: _____ Male Female

Home Address: _____ Apt/Ste#: _____

City: _____ State: _____ Zip: _____

Home Number: () _____ - _____ Work/Cell Number: () _____ - _____

Occupation: _____ Employer: _____

Work Address: _____ City _____ State: _____ Zip: _____

Spouse's Name: _____ Phone Number: () _____ - _____

E-mail address (for communication & newsletters): _____

Chief Complaint: _____

Please answer the following questions by circling Yes or No

Do you have a tendency to faint?	Yes	No	Are you HIV positive?	Yes	No
Do you have a pacemaker?	Yes	No	(Females) Are you pregnant?	Yes	No
Do you bleed for a long time?	Yes	No	What medications are you on now?	_____	
Have you ever had hepatitis?	Yes	No	_____		

INSURANCE INFORMATION:

(For Health Insurance Form Completion Purposes)

Name of Insurance Co.: _____ Insured's Name: _____

Insured's ID #: _____ Insured's Date of Birth: ____/____/____ Relation: _____

EMERGENCY CONTACT:

Name: _____ Relation: _____ Phone Number: () _____ - _____

Primary Physician's Name: _____ Phone Number: () _____ - _____

REFERRED BY:

Name: _____ Referral Phone Number: () _____ - _____

Referral Address: _____

Other: e.g. askdrmao.com, taoofwellness.com, Google, etc.: _____

**If you are under 18 years of age, please have your parent or legal guardian sign below.
I have read and agree to the terms above. All of the information is true to the best of my knowledge.**

X _____ Date: _____
Signature of Patient/Parent/Legal Guardian

X _____ Relation: _____
Printed Name of Patient/Parent/ Legal Guardian