Tracy Andrews, LAc
3133 NE Prescott Street
Portland OR, 97211

New Patient Intake

CONFIDENTIAL PERSONAL INFORMATION

Full Name:_____/_____/_____
(Last Name) (First Name) (Middle Initial)
Preferred Name: _____ Age: _____ Date of Birth: _____
Address:_____/_____/____/_____
(street#/PO Box) (city) (state) (Zip code)
Telephone#(____)_____/_(____)_____/_(____)_____
(home) (work) (cell phone or other)
E-mail address: _____
**I occasionally send email newsletters with updates on events, educational opportunities, special offerings, etc. This usually happens a few times a year, and no more than once a month. You may opt out at any time by following links in the emails. Please initial here if you do NOT want to receive these___.*

Sex: female _____ male _____ other/preferred pronoun? _____
Are you (check one): Single ____ Partnered ____ Married ____Widowed/widower ____
Partner's Name: _____

Occupation: _____(circle) full-time/part-time/student/retired/unemployed
Employer: _____

Do not enter insurance information if we are not billing insurance for you.
Insurance company _____
Insured's Name _____ Insured's DOB _____
Insured's Address (if different) _____
Insurance ID No.: _____ Group No. _____
Acupuncture coverage? Y or N Co-pay amount or coinsurance rate _____
Yearly deductible _____ Plan year dates _____ Deductible met? Y or N

Please note that payment is due at the time of service. We will bill your insurance company but you will be responsible for payment in full if your insurance company does not pay your claim. Please note that we cannot bill Kaiser/CHP out of network.

Is the reason for your visit due to a motor vehicle or work-related accident? (Circle) Y N
Claim # (MVA or Worker's Comp) _____
Adjustor: _____ Phone: _____

Emergency Contact _____ /_____
(Name) (Relationship)
(_____)_____(_____)_____
(Day Phone) (Evening Phone)

What is the **best way** to communicate with you between office visits?
Circle one: E-mail, Home, Work, Cell Phone
Is there any place you do **NOT** want me to leave a message? _____

By signing below, I verify that the above information is correct and true to the best of my knowledge.
Signature of Patient _____**Today's Date**_____