Burt R. Durfee, L. Ac. & Assoc.
STATE LICENSED ACUPUNCTURIST

Patient Information

Please Print

(Circle one) Miss / Mrs. / Ms. / Mr. / Dr.

Patient's Name: _____M / F_____

Responsible Party or Legal Guardian

Responsible Party's Name: _____M / F _____
(If different than patient's name) First Middle Last Birth Date

Email Address _____

Home Address: _____Home Phone_____
Street Apt #

_____
City State Zip

Cell Phone_____

Who referred you to our online service? _____

I understand that total payment of the fees for services performed are my responsibility and not that of the insurance company and are due at the time of service.

_____ _____
Patient's Signature or Legal Guardian (must be over 18 years of age) Date