



# Metro Acupuncture

6255 Barfield Road, Suite 175

Atlanta, GA 30328

404 255-8388

[www.metroacupuncture.com](http://www.metroacupuncture.com)

## Patient Information

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Preferred Contact # \_\_\_\_\_ Email: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Who referred you or how did you hear about Metro Acupuncture? \_\_\_\_\_

Who is your primary care physician? \_\_\_\_\_

## Payment Information

Person responsible for payment: \_\_\_\_\_

Address - If different from above: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

I understand that payment is due at the time of service. Our office will provide you with documentation in order to file with your insurance carrier for reimbursement.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_



Patient Name: \_\_\_\_\_

<b>Accidents</b>			
Please list all major accidents, including fractures, deep cuts and wounds, serious sprains, etc.			
<b>Injury</b>	<b>Date</b>	<b>Age</b>	<b>Description</b>
<b>Surgeries</b>			
Please list all surgeries, elective or necessary, and any consequence from procedure.			
<b>Surgery</b>	<b>Date</b>	<b>Age</b>	<b>Outcome</b>

List any allergies or food sensitivities.

<b>Substance</b>	<b>Reaction</b>

Patient Name: \_\_\_\_\_

Please indicate with check (√) if you now or have had any of the following symptoms or diseases.					
Now	Past		Now	Past	
		Allergies			Heart murmur
		Anemia			Heart palpitations
		Anxiety			Hepatitis – Type: _____
		Arthritis			Herpes
		Asthma			Hypertension
		Bruising			Hypotension
		Cancer			Hyperthyroidism
		Candida			Hypothyroidism
		Cholesterol, high			Kidney stones
		Chronic fatigue			Low sex drive
		Constipation			Mental illness
		Depression			Mononucleosis
		Diabetes			Nose bleeds
		Diarrhea			Numbness
		Digestive problems			Prostate issues
		Dizziness, vertigo			Sciatic pain
		Edema			Skin problems
		Epilepsy			TMJ
		Food allergies			Ulcers
		Frequent colds			Venereal disease
		Frequent gas			Vision issues
		Gallstones			- near sighted
		Hay fever			- far sighted
		Head injury			- use reading glasses
		Headache			

Other symptoms or diseases (please list):

---



---



Patient Name: \_\_\_\_\_

Please answer the following questions if you are undergoing assisted reproductive technologies.

<b>Assisted Reproduction</b>	
Are you working with a Reproductive Endocrinologist? Yes: ___ No: ___	
If Yes – Name of group: _____	
Name of physician: _____ _____	
Number of IUI's _____	Dates: _____
Number of IVF's _____	Dates: _____
Upcoming procedure: _____ Date: _____	
Hysteroscopy date: _____	
Laparoscopic surgery date: _____	
Reason: _____	
Previous abdominal surgeries:	
Date: _____	Reason: _____
Date: _____	Reason: _____
Date: _____	Reason: _____
Date: _____	Reason: _____
_____	
_____	
_____	
Pertinent Lab Information:	
FSH: _____	
AMH: _____	
Other: _____	
_____	



## Metro Acupuncture

6255 Barfield Road, Suite 175

Atlanta, GA 30328

404 255-8388

FAX: (404) 255-1831

[www.metroacupuncture.com](http://www.metroacupuncture.com)

**To protect the privacies of our patients please respond to the following questions.**

<b>Please indicate your answer with a check to the right of each question.</b>	<b>Yes</b>	<b>No</b>
Do we have your permission to correspond with you through the USPS mail at home or work? (Examples include: sending appointment reminders, birthday wishes, or a thank you notes when you have made a referral to us)		
Do we have your permission to correspond with you via the E-mail address you have provided?		
Do we have permission to contact your doctor(s)?		
If photographed for the purpose to training or teaching, do we have your permission to use the photograph(s) to share, publish or use in a presentation?		

\_\_\_\_\_  
Signature of Patient or Legal Guardian

\_\_\_\_\_  
Date



## Metro Acupuncture

6255 Barfield Road, Suite 175

Atlanta, GA 30328

404 255-8388

FAX: (404) 255-1831

[www.metroacupuncture.com](http://www.metroacupuncture.com)

### **Patient Consent for Use and Disclosure of Protected Health Information**

***With my consent***, Metro Acupuncture may use and disclose health information [treatment, payment or healthcare operations (TPO)] about me to carry out treatment, payment, and healthcare operations (TPO). Please refer to Metro Acupuncture's Notice of Privacy for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Metro Acupuncture reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Metro Acupuncture at 6255 Barfield Road, Suite 175, Atlanta, GA 30328.

With my consent, Metro Acupuncture may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, Metro Acupuncture may mail my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

With my consent, Metro Acupuncture may e-mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminders and patient statements. I have the right to request that Metro Acupuncture restricts how it uses or discloses my Protected Health Information (PHI) to carry out TPO.

By signing this form, I am consenting to Metro Acupuncture use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Metro Acupuncture may decline to provide treatment to me.

\_\_\_\_\_  
Signature of Patient or Legal Guardian

\_\_\_\_\_  
Patient's Name

\_\_\_\_\_  
Date





## Metro Acupuncture

6255 Barfield Road, Suite 175

Atlanta, GA 30328

404 255-8388

[www.metroacupuncture.com](http://www.metroacupuncture.com)

### POST-ACUPUNCTURE INSTRUCTIONS

(Please read before your treatment)

1. Immediately after your acupuncture session it is possible that you may become euphoric or light-headed. Please be sure you are properly oriented before leaving. We offer water and you are welcome to stay in the treatment room or in the lobby until you are capable of walking or driving safely from our office.
  
2. For 8-12 hours following your treatment:
  - Engage in your normal daily activities, however, wait 24 hours before performing any strenuous physical activities.
  - Refrain from alcohol or other mind/mood altering substances.
    - If you choose to consume these substances, be aware their effect will be magnified.
  - Eat moderately sized and satisfying meals (avoid spicy foods).
  - If you feel sleepy or tired following your treatment, please honor those feelings by resting as needed.
  
3. We at Metro Acupuncture are dedicated to providing the highest possible level of care and strive for constant improvement; therefore, we welcome and encourage you to share your experience with us. Please feel comfortable offering us your opinion(s) in the form of a suggestion, comment, and or concern by discussing these matters with your practitioner, writing to us directly via mail or sending an E-mail from our website at [www.metroacupuncture.com](http://www.metroacupuncture.com).

**Thank you for choosing Metro Acupuncture to support your health and wellness.**