

CONFIDENTIAL

Health Insurance Information

Please take a moment to provide us with some information about yourself and the condition of your health so that we may do our *best* to treat you. **Beijing Modern Acupuncture** considers this information *privileged* acupuncturist-patient communication and will hold it in complete *confidence*.

*Beijing Modern
Acupuncture*

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www.bmacupuncture.com

Please print, fill it out and bring form to your appointment

Patient Name:
(Last) (First)

Birthdate:
MM/DD/YYYY

Employer's Name:

Patient SSN:

Health Insurance

Primary Insurance

Secondary Insurance

Ins. Company Name:

Member Card ID:

Account #:

Plan Name:

Plan Number:

Sub Name:

Group Name/#:

Phone for Provider:

Phone for Member:

Effective Date:

Account Holder

Name:

Birthdate:

Relationship:

Contact Phone:

Home Address:

City

State

ZIP

City

State

ZIP

Patient/Guardian Signature

Date

Eligibility

(Area below will be used in Clinic)

Co-Pay

Co-Insurance

Visit/Year

Deductible