Hanbiao Cao, L.Ac,, Dipl.Ac.

2014 S. Tollgate Rd., Ste. 109
Bel Air, MD 21015
Tel (410) 901-7668

14201 Laurel Park Dr., Ste. 219
Laurel, MD 20707
Tel (301) 617-0700

Fax (301) 357-8486

Patient Information

Name: _____
(Please Print) Last First Middle init.

Date of Birth: _____/_____/_____ Sex: Male/Female Marital Status: S, M, D, W
MM DD YYYY

Home Address: _____

City: _____ State: _____ Zip Code: _____

SSN: _____ Email Address: _____

Phone: (H) _____ (W) _____x_____(C) _____

Employer: _____ Occupation: _____

Next of kin (or emergency name) _____ Phone: _____

Insurance Information

Primary Insurance: _____

Policy No: _____ Group No: _____ Co-Pay: _____

Insured's Name: _____ SSN: _____

Date of Birth: _____/_____/_____ Sex: Male/Female Relation to Insured: _____
MM DD YYYY

Insurance Address: _____

Insurance Phone No: _____
(If any other insurances please fill in on next page)

ACUPUNCTURIST OF THIS OFFICE HAS MY PERMISSION TO KEEP MY SIGNATURE ON FILE. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES FOR SERVICES RENDERED TO ME, INCLUDING THE BALANCE REMAINING AFTER PAYMENT OF POSSIBLE INSURANCE BENEFITS.

X_____ _____
Signature of Patient (Parent/Guardian) Date

Second Insurance: _____

Policy No: _____ Group No: _____ Co-Pay: _____

Insured's Name: _____ SSN: _____

Date of Birth: _____/_____/_____ Sex: Male/Female Relation to Insured: _____
MM DD YYYY

Insurance Address: _____

Insurance Phone No: _____

X_____ _____
Signature of Patient (Parent/Guardian) Date

Your Primary Doctor _____ Phone _____

Who Referred You to us _____

Patient Name (Print) _____

AUTHORIZATION OF PATIENT OR AUTHORIZED PERSON

I authorize the release of any medical or other information necessary to process my claim. I also request payment of government benefits either to me or to the party who accepts assignment described in the claim form.

I authorize payment of medical benefits to the undersigned acupuncturist for any services described in the claim form.

X_____ _____
Signature of Patient (Parent/Guardian/Authorized person) Date

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