BASIN
NATURAL MEDICINE
Transforming Health Naturally

New Patient Form____Todays Date:__________

Name:_______________________________________Age:_______ (M)(F) Birthdate:__________

Address:______________________________ City:_________________ State:________ Zip:___________

Best Phone Contact:__________________________ Email:______________________________________

Occupation:_________________________________ Work#:_____________________________________

Do you have a primary care physician? yes no Physicians name:__________________________

Have you had Acupuncture before? yes no Chinese herbal medicine? yes no

Emergency Contact:_____________________ Phone #:_____________________ Relationship:__________

Insurance Information

Insurance Co:__________________________________ Phone #:____________________________________

Address:______________________________ City:_________________ State:________ Zip:___________

Member ID #:__________________________ Group #:____

Insured name:______________________ M F Birthdate:_________________________________

Insured Address:______________________________ City:_______________State:______Zip:_________

Relationship to insured:________________________

Secondary Insurance Coverage? yes no

Insurance Co:__________________________________ Phone #:____________________________________

Address:______________________________ City:_________________ State:________ Zip:___________

Member ID #:__________________________ Group #:____

Insured name:______________________ yes no Birthdate:____________________________

Insured Address:______________________________ City:_______________State:______Zip:_________

Relationship to insured:________________________