Meridian Health Clinic - Eric Schmidt, L.Ac.
2020 Broadway St, Suite A, Santa Monica, CA 90404
(310) 699-4533 • MeridianHealthClinic.com

PATIENT INFORMATION

DATE _____/_____/20_____ ACCOUNT NO _____

LAST NAME _____ FIRST NAME _____ MIDDLE _____

DATE OF BIRTH _____/_____/_____ (MM DD YYYY) SEX: MALE / FEMALE MARITAL STATUS: M S D W

EMAIL _____

HOME ADDRESS _____

CITY _____ STATE _____ ZIP _____ PHONE _____

EMPLOYER _____ OCCUPATION _____

WORK ADDRESS _____

EMERGENCY CONTACT _____ RELATION _____

EMERGENCY CONTACT PHONE _____

REFERRED PHYSICIAN _____ PHONE _____

INSURANCE COVERAGE:

*Please complete the form below only if you have coverage for acupuncture and you would like our office to generate a "Superbill" that can be submitted to your insurance plan.

INSURANCE NAME _____

SUBSCRIBER _____ DOB _____/_____/_____

AUTHORIZATION TO SEND SUPERBILL:

I HEREBY AUTHORIZE ERIC SCHMIDT, LAc/MERIDIAN HEALTH CLINIC (MHC) TO SEND ME A "SUPERBILL" FOR INSURANCE BILLING PURPOSES VIA EMAIL. I UNDERSTAND THAT THIS SUPERBILL WILL CONTAIN PERSONAL INFORMATION INCLUDING BIRTH DATE AND DIAGNOSIS CODES THAT ARE REQUIRED FOR INSURANCE BILLING PURPOSES. I UNDERSTAND THAT MHC WILL NOT BE ABLE TO PROCESS ANY ADDITIONAL FORMS OR PAPERWORK RELATED TO INSURANCE BILLING.

IN RARE CASES MHC MAY BE REQUIRED TO CONTACT MY INSURANCE COMPANY DIRECTLY. FOR THESE CASES I AUTHORIZE THE RELEASE OF MY RECORDS TO THE INSURANCE COMPANY FOR BILLING OR REPORTING PURPOSES.

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES AT THE TIME OF TREATMENT. I UNDERSTAND THAT I KEEP ALL INSURANCE PAYMENTS ISSUED DIRECTLY TO ME AND THAT MHC RELEASES ALL CLAIMS TO THESE INSURANCE PAYMENTS.

LASTLY, I UNDERSTAND THAT MHC DOES NOT HANDLE PI CASES (AUTO) OR WORKER'S COMP CASES AND THEREFORE WILL NOT BE ABLE TO PROVIDE PAPERWORK OR DOCUMENTATION FOR THESE CASES.

_____
PATIENT / GUARDIAN / INSURED

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Dear Valued Customer,

Please complete this questionnaire before your first treatment. All the information will be held confidential unless otherwise required by law or you agree this information may be shared for insurance or healthcare reasons.

Thank You, Eric Schmidt, LAc.

How did you hear about us? _____

HEALTH INFORMATION

Please identify your health concerns listed in order of importance below:

Condition & Date Began **Diagnosis & Past Treatment**

1. _____ _____

Details: _____

_____

_____

2. _____ _____

Details: _____

_____

_____

Personal Medical History (Include Dates):

Major Surgeries or Illnesses: _____

Known Allergies (food or drug): _____

Current Medications & Supplements: _____

Lifestyle:

a. Occupation: _____ Hours/Week: _____

b. How many hours per night do you sleep? _____ Do you wake rested? Y / N

c. Diet: List any dietary specifics including avoided foods: _____

_____

Cravings: _____

Meals per day? _____ Water per day (8 oz glasses)? _____

d. Nicotine/Alcohol/Caffeine Use (give the number per day if applicable):

_____Coffee _____Black Tea _____Soft Drinks _____Cigarettes _____Alcohol

e. Exercise routine: _____

f. Interests and hobbies: _____

g. Activities you do for relaxation: _____

Body Pain:

How did your pain begin: ☐ Gradually? ☐ Suddenly?

Please describe when and how it began: _____

_____

_____

Do you have pain: ☐ All the time? ☐ Sometimes?

How painful is your condition on a scale from 1-10: _____

(1 = Slight Pain, 10 = Extreme Pain)

Is your pain worse when you:

☐ Sit ☐ Bend ☐ Walk ☐ Lift ☐ Push ☐ Pull ☐ Other: _____

Does your pain interfere with: ☐ Work? ☐ Sleep? ☐ Daily Routine?

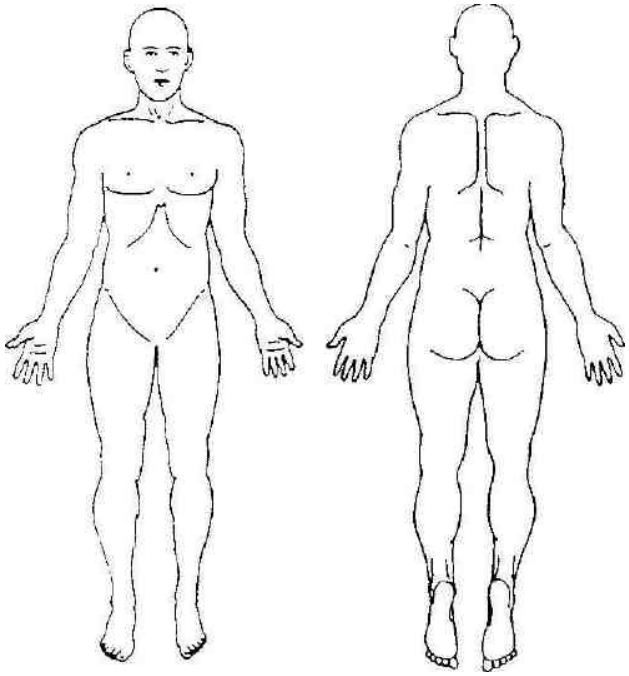
Do you feel your present condition is:

☐ Temporary? ☐ Permanent? ☐ Don't know

Please mark areas of pain on the figure to the right using the codes:

Burning: +++ Sharp: ✍ ✍ ✍ Dull: **000**

Worse with Cold: **CCC**



Have you been treated for emotional problems? Y / N

Have you ever considered or attempted suicide? Y / N

Any other problems you would like to discuss? _____

The information given here is true to the best of my knowledge:

Signature: _____ Date: ____/____/20_____

Women Only: please check if you have any of the following:

Past	Current		Past	Current		Past	Current	
___	___	Abnormal PAP smear	___	___	Hot flashes	___	___	Breast lumps
___	___	Pain with menstruation	___	___	Menopause	___	___	Scanty bleeding with period
___	___	Birth control pill use	___	___	IUD use	___	___	Sickness/weakness
___	___	Bleeding between periods	___	___	Infertility	___	___	Vaginal discharge/sores
___	___	Bleeding during/after sex	___	___	Clots in flow	___	___	Vaginal dryness/itching
___	___	Bloating before periods	___	___	PMS	___	___	Heavy bleeding with period
___	___	Irregular periods	___	___	Endometriosis	___	___	Breast swelling or pain

Interval between periods: _____ **Duration of menstrual periods: _____** **Date of last period: ____/____/20_____**

Number of pregnancies: _____ **Births: _____** **Are you pregnant? Y / N**

Method of birth control: _____