Jenna DePino, L.Ac. 619-573-5164
2738 Loker Avenue West, Ste. A, Carlsbad, CA 92010

Patient Acknowledgement

I have received and understand this practice's Notice of Privacy Practices written in plain language. The notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights and the practice's legal duties with respect to my protected health information. This includes, but is not limited to:

- A statement that this practice is required by law to maintain the privacy of protected health information
- A statement that this practice is required to abide by the terms of the notice currently in effect.
- Types of uses and disclosures that this practice is permitted to make for each of the following purposes: treatment, payment, and health care operations.
- A description of each of the other purposes for which this practice is permitted or required to use or disclose protected health information without my written consent or authorization
- A description of uses or disclosures that are prohibited or materially limited by law.
- A description of other uses and disclosures that will be made only with my written authorization and that I may revoke such authorization.
- My individual rights with respect to protected health information and a brief description of how I may exercise these rights in relation to:
  - The right to complain to this practice and the Secretary of HHS if I believe my privacy rights have been violated, and that no retaliatory actions will be used against me in the event of such a complaint.
  - The right to request restrictions on certain uses and disclosures of my protected health information, and that this practice is not required to agree to a requested restriction.
  - The right to receive confidential communications of protected health information.
  - The right to inspect and copy protected health information.
  - The right to amend protected health information
  - The right to request and accounting of disclosures of protected health information
  - The right to obtain a paper copy of the Notice of Privacy Practices from this practice upon request.

This practice reserves the right to change the terms of its Notice of Privacy Practices and to make new provisions effective for all protected health information that it maintains. If changes occur, this practice will provide me a revised Notice of Privacy Practices upon request.

Signature: ______________________________ Date: ____________________

Relationship to patient (if signed by a personal representative): ______________________________

Witnessed by: ______________________________

CONFIDENTIAL CASE HISTORY

Jenna DePino, L.Ac. 619-573-5164
2738 Loker Avenue West, Ste. A, Carlsbad, CA 92010

Last Name		First Name	
Home Address		City	Zip
Home Phone ( )	Work Phone ( )	Cell Phone ( )	
SSN -- --		E-mail	
Date of Birth (mm / dd / yy)	Gender ☐ Male ☐ Female	Marital Status: ☐S ☐M ☐W ☐D ☐Sep	
Spouse's / Parent's Name		Permission to Leave Message: ☐ YES ☐ NO	
Home Phone ( )	Work Phone ( )	Cell Phone ( )	
Employer		Occupation	
Address		Phone	

Emergency Contacts		
	Name:	Name:
	Phones:	Phones
	Address:	Address:

Primary Insurance Company:	
Group #	ID #
Name of Insured	Relationship to Patient
Secondary Insurance Company:	
Group #	ID #
Name of Insured	Relationship to Patient

I, the undersigned certify that I (or my dependent) has insurance coverage with ___________________ and assign directly to ~~Jenna DePino, L.Ac~~. all benefits, if any, otherwise payable to me for services rendered. I hereby authorize release of all information necessary to secure payment of benefits. I further authorize the use of my signature on all insurance submissions. If my health insurance company denies payment to the acupuncturist, I understand that I am responsible for the full amount

Signature
Date (mm / dd / yy)

Date of Last Medical Exam mm / dd / yy	Doctor's Name	Phone:
Have you seen an Acupuncturist before? ☐Yes ☐ No	When?	With Whom?

Please list ALL of your Prescription medications taken on a regular basis (include birth control)

Name	Dose	Reason	Date Started	Prescribed By

Use the back of this sheet if additional paper is necessary

Non-Prescription medications you take (include vitamins / minerals / herbs)

Name and brand	Reason	Date Started

Use the back of this sheet if additional paper is necessary

Please check box if you currently experience or have ever experienced any of the following symptoms or conditions:

☐ High Blood Pressure	☐ Difficulty Breathing	☐ Asthma/Wheezing	☐ Depression	☐ Tuberculosis	☐ Stroke
☐ Low Blood Pressure	☐ Shortness of Breath	☐ Acid regurgitation	☐ Anxiety	☐ HIV/AIDS	☐ Pacemaker
☐ Chest Pain	☐ Diarrhea/Constipation	☐ Pneumonia	☐ Insomnia	☐ Hepatitis	☐ Fainting
☐ Heart Attack	☐ Urinary difficulty	☐ Seizure / Epilepsy	☐ Headaches	☐ STI/STD	☐ Irregular Heart Beat

Lifestyle – record the number of times per week:

Alcohol	Tobacco	Soda	Exercise	Water	Recreational Drugs

Allergies		
	Medications	Have you ever had an allergy test? ☐ YES ☐ NO
	Food	
	Seasonal (pollen, dust)	