Dr. Puquan Xiao, OMD, LAc, PhD
TID # 20-4051430 NPI: 1073608725
2633 E Indian School Rd; Suite 220; Phoenix, AZ 85016
Phone: 602-522-9988 Fax: 602-667-9988

PATIENT REGISTRATION FORM

Part One: Personal Information

Last name___________________________ First name________________________ Today's Date _______________
Date of birth________________ Sex: ☐M ☐F
Marital Status: _________________________ Height______ ft_______ in Weight __________lbs
Telephone _________________________________ Cell____________________________________
Email: ____
Home address____
City____________________________________ State_________________ Zip__________________________________

How did you hear about Yangtze Medical Center?
☐Yellow Pages ☐Ad ☐A talk ☐Brochure☐Business Card ☐ Web Site
☐Referred by____

Part Two: Employer Information

Occupation_______________ Employer's Name____
Address ____
City_______________________________________ State_________________ Zip_____________________________
Tel__________________________________ Website:____

Part Three: Notify in Case of Emergency

Name____ Tel___________________________

Relationship to Client____

Part Four: Specific Medical History

Have you had Chinese Medicine before? ☐Acupuncture☐Herb ☐TuiNa ☐GuaSha ☐ Moxibustion

Reason for your visit today____
____

Do you currently have any infectious diseases? ☐ Yes ☐No ☐ Possibly
If Yes or Possibly, please identify: ☐HIV ☐Hepatitis B ☐Hepatitis C ☐Flu ☐Cold ☐Strep ☐Mono ☐Tuberculosis
☐Other Explain____

Known or suspected allergies:____

I am taking Coumadin / Warfarin/ Aspirins ☐Yes ☐No I have a pacemaker ☐Yes ☐No

Part Five: Health Inventory

1. **Cardiovascular Conditions**: ☐Heart Disease ☐ Pacemaker ☐High Blood pressure☐ Low Blood Pressure
☐ Chest Pain ☐Palpitations ☐ Stroke ☐ Varicose Veins ☐ Edema
Medications for any of these conditions:____

2. **Emotional/Immunity**: ☐Clinical Depression ☐Mild Depression ☐ADD/ADHD ☐Schizophrenia☐Mood Swings
☐Panic Attacks ☐Nervousness ☐Anxiety ☐Alzheimer's ☐Dementia
Medications for any of these conditions:____

3. **Energy & Immunity** ☐Chronic Fatigue Syndrome ☐General Fatigue □ Slow Wound Healing ☐ Easy Bruising
☐Chronic Infections ☐Frequent Allergies
Medications for any of these conditions:____

4. **Respiratory**: ☐Pneumonia □Asthma ☐Frequent Common Colds ☐Difficulty breathing □ Emphysema
☐Persistent Cough ☐Pleurisy ☐Tuberculosis ☐Shortness of breath
Medications for any of these conditions:____

5. **Muscular –Skeletal**: ☐Neck/Should Pain ☐Muscle Spasms /Cramps ☐ Arm Pain ☐Upper Back Pain
☐Mid Back Pain ☐ Low Back Pain ☐ Hip Pain ☐ Leg Pain ☐ Knee Pain ☐Ankle Pain ☐ Heel Pain
☐Osteoporosis ☐Arthritis ☐Joint Pain
Medications for any of these conditions:____

6. **Head, Eye, Ear, Nose & Throat**: ☐Impaired Vision ☐Eye Pain/ Strain ☐Glaucoma☐Glasses/ Contacts
☐ Tearing/Dryness ☐Impaired Hearing ☐ Ear Ringing ☐Earaches ☐Ear Infections ☐ Headaches ☐ Sinus Problems
☐Nose Bleeds ☐Teeth Grinding ☐ Frequent Sore Throats ☐TMJ/ Jaw Problems ☐Hay Fever
Medications for any of these conditions:____

7. **Genital-Urinary Tract**: ☐Kidney Disease ☐ Kidney Stones ☐ Painful Urination ☐ Dribbling Urination
☐ Frequent Urination ☐Blood in Urine ☐Discharge ☐ Incontinence
Medications for any of these conditions:____

8. **Neurological**: ☐Vertigo/ Dizziness ☐Paralysis ☐ Numbness/Tingling ☐ Loss of Balance
☐Seizures/Epilepsy ☐Dyslexia
Medications for any of these conditions:____

9. **Gastrointestinal**: ☐ Stomach Ulcers ☐ Changes in Appetite ☐ Nausea / Vomiting ☐ Epigastria/ Abdominal Pain
☐Passing Gas Heart Burn ☐ Belching ☐Gall Bladder Disease ☐Gall Bladder Stones ☐ Hemorrhoids
☐ Constipation ☐ Diarrhea ☐ Irritable Bowel Syndrome ☐ Leaky Gut Syndrome
Medications for any of these conditions:____

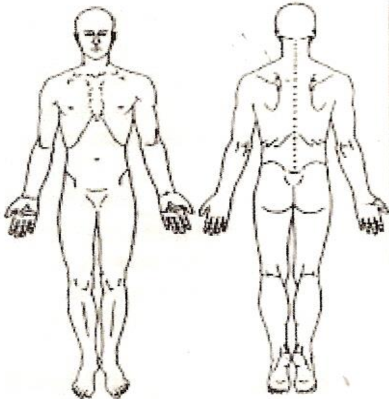
10. **Endocrine**: ☐Hypothyroid ☐ Hypoglycemia ☐Hyperthyroid ☐ Diabetes Type I ☐ Diabetes II ☐Night Sweats
☐Unusual Sweating ☐ Feeling Hot or Cold
Medications for any of these conditions:____

11. **Other:** ☐Cancer- Type (____________________________) ☐Fibromyalgia ☐Lupus ☐Candida ☐Anemia
☐Rashes ☐Eczema/Hives ☐ Cold Hand/Feet ☐Hemophilia ☐Thin/ graying hair
Medications for any of these conditions:____

12. **Male only:** ☐Impotence ☐ Prostate Problems ☐ Testicular pain/Redness/Swelling ☐Low Libido
☐ Painful Intercourse ☐ Seminal Emissions ☐Vasectomy Date (________________________)
Medications for any of these conditions:____

13. **Female only:** Are you Pregnant right now? ☐Yes ☐No ☐ Trying ☐Maybe
Method of Birth Control_________________
Age at first Period: _______ Date of last menses: ____/m_____/d_____/yr
Typical Length of menses (1.-7days):__________________ Typical length of cycle (29-23days) __________________
Number of: _____Pregnancies______ Birth ____ Abortions ____Miscarriages
Age at Menopause: _________ ☐ Hysterectomy: ☐Yes ☐No Date__________________________
☐Low libido ☐ Excessive Libido ☐Painful Intercourse ☐ Clotting ☐Painful Periods ☐ Heavy Flow☐Scanty Flow
☐ bleeding between Cycles ☐ Irregular Cycles ☐ vaginal Discharge ☐ Breast Lumps/Tenderness ☐Nipple Discharge
☐Infertility ☐Menopausal Symptoms ☐Premenstrual Problems ☐ Endometriosis ☐Fibroids ☐Fibrocystic Breasts
☐Ovarian Cysts ☐ Abnormal Pap smear
Medications for any of these conditions:____

Part Six: Pain Information



Mark the diagram to show where the area of pain is:

Please answer the following question if you have pain:

1. On a scale of 1-10 (10 being the worst) how strong is your pain?

☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

2. Quality of pain:

☐Dull ☐Sharp ☐ Stabbing ☐Sore ☐Cramping ☐Burning

☐ Constant ☐Fixed ☐ Moves about

3. Does the pain radiate? ☐Yes ☐ No Where?___________________

4. What helps the pain ☐Ice ☐ Heat ☐ Rest ☐ Movement ☐ Pressure

☐ Moisture☐ Massage ☐Nothing

5. Does any medication help your pain?____

6. Other treatments you have had for your pain? ____

____

7. Describe the onset of your pain (How long, how it happened, etc.):

____

____

____

Part Seven: Client Signature

The above information is true to the best of my knowledge. I understand and accept that I am responsible for full payment of my account and that payment is expected at the time of service. I also understand and accept that I am expected to notify Yangtze Medical Center 24 hours prior to any cancellations or changes to my appointment times and that if I do not I will be charged an $80 cancellation/No Show fee.

Client Signature ____________________________________ Date__________/__________/___________________

Or Legal Guardian Signature__________________________ Date_________/_________/_____________________

Print Signatory's Name: ________________________________

Dr. Puquan Xiao, OMD, LAc, PhD 2633 E Indian School Rd Suite 220 Phoenix AZ 85016

INFORMED CONSENT AND DISCLOSURE

I hereby request and consent to acupuncture treatment and/or herbal supplement recommendations for me (or my legal charge) provided by Yangtze Medical Center. I understand that Yangtze Medical Center will explain all known risks and complications, and I wish to rely on Yangtze Medical Center to exercise judgment during the course of the procedure, which Yangtze Medical Center determines is in my best interests. I may request another person of my choice to be present in the treatment room during the treatment.
Yangtze Medical Center has discussed with me the procedures listed below that may be used in my treatment. I have read the information below and understand the possible risk involved. I agree to Yangtze Medical Center use of this treatment (*if indicated*).

- **Acupuncture** is a safe and effective method of treatment. However, it can occasionally cause slight bleeding that usually resolves with pressing dry cotton on the spot where the skin is bleeding. It is also normal for the patient to have a temporary warm, tight, sore or tingling sensation at the acupuncture site.
- **Acupressure/TuiNa** involves rubbing, kneading, pressing, and stroking, etc., which may result in muscle soreness at the massage site that can last several days. This technique may require disrobing. I understand all attempts will be made to assure my privacy.
- **Indirect Moxibustion** requires burning an herbal material near the skin or on an acupuncture needle. Every precaution is taken to prevent skin contact, but the possibility of skin contact and mild burns exists. Yangtze Medical Center does not allow direct moxibustion where material contacts the skin.
- **Cupping** involves a localized suction produced by heating a small glass cup. There is a possibility of local bruising from the suction and slight burning or blistering due to the heat involved in the technique.
- **Gua Sha** involves scraping over a small area by using a smooth-edged instrument. There is a possibility that local bruising is likely to occur at the site where Gua Sha is performed.
- **Tapping, Plum Blossum, Bleeding, Pricking** all involve multiple needle pricks at a localized site. Slight bleeding and/or bruising at the treatment site is a likely occurrence. Only single-use needles are used in these procedures.
- **Electrical Stimulation/TENS** uses microcurrent electricity to stimulate acupuncture points. A mild tingling sensation of electricity will be felt.
- **Treatment Using Control Points Ren 1/Du 1.** In very rare cases, Yangtze Medical Center may recommend treatment using acupuncture points near the genital organs. If this is necessary, Yangtze Medical Center will notify me and will provided alternative treatments if I am uncomfortable with treatment using these points. I understand all attempts will be made to assure my privacy.

I have read, or have had read to me, the above consent, and have had the opportunity to ask questions and discuss this with Yangtze Medical Center. I consent to the treatment that involves the above procedures for my present condition(s) and any future conditions. I have the right to refuse or discontinue any treatment at any time and understand that this refusal may affect the expected results.

Authorization for Release of Medical Information: I further understand that Yangtze Medical Center may need to contact my medical physician if and when they have identified that my condition needs to be co-managed with my medical doctors. The conditions that may require co-management include but are not limited to; pregnancy related nausea, pain associated with Multiple Sclerosis, neuromusculoskeletal effects of stroke, pain/nausea related to cancer/tumor, chemotherapy related nausea,
pain/nausea related to AIDS/ARC, pain or nausea related to surgery. This coordination of care intends to manage my health condition in my best interest and assure the optimal outcome of my acupuncture treatments. Therefore, I give my authorization to Yangtze Medical Center to contact my medical physician if/when necessary.

Treatment of Pediatric Patients < 3 years: I understand that treatment of young children has some risk and should be coordinated with the child's physician. If I am signing for my child under the age of eighteen (18), I give my authorization to Yangtze Medical Center to contact my child's medical doctor if/when necessary.

______________________________	______________________________
Patient Name (please print)	Patient ID Number
______________________________	______________________________
Primary Care Physician (or specialist) Name	Patient Signature
______________________________	______________________________
Primary Care Physician Telephone Number	Date

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Financial Policy

Yangtze Medical Center is committed to providing the highest level of quality service to our patients.

PAYMENT IS REQUIRED AT TIME OF SERVICE. We accept cash, check, Visa, MasterCard, Discover and American Express.

INSURANCE IS NOT ACCEPTED FOR PAYMENT. Upon request, we will provide detailed billing invoices for you to self-file your insurance claims. Any insurance reimbursements would be sent directly to you from your insurance company.

CANCELLATION MUST BE MADE AT LEAST 24 HOURS PRIOR TO YOUR APPOINTMENT. We understand that there are times when you may miss an appointment due to an emergency or a family/work obligation. When a situation arises, please call our office as soon as possible so that we can reschedule and open the appointment for someone else. **Cancellations made less than 24 hours in advance will be subject to an eighty dollar ($80) cancellation fee. Payment of this fee will be required at your next appointment.**

PATIENTS THAT DO NOT SHOW UP FOR A SCHEDULED APPOINTMENT WILL BE ASSESSED AN eighty dollar ($80) NO SHOW FEE. Payment of this fee will be required at your next appointment.

LATE ARRIVALS MAY BE RESCHEDULED. We understand that delays can happen. If you are running late, please call our office. We will attempt to accommodate your late arrival or reschedule you if necessary.

Patient/Responsible Party (Signature)	Patient/Responsible Party (Print)
Relationship to Patient	Date

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HIPAA Privacy Authorization Form

AUTHORIZATION TO RELEASE PROTECTED HEALTHCARE INFORMATION

Patient's Name: ______________________________ Date of Birth: ______________________________

I request and authorize ____ to release healthcare information of the patient named above to:

Name: ____

Address: ____

City: ______________________________ State: __________ Zip Code: ______________

This request and authorization applies to:
☐ Healthcare information relating to the following treatment, condition, or dates: ________________________

____

☐ All healthcare information

☐ Other: ____

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereuem, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

☐ Yes ☐ No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

☐ Yes ☐ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient Signature: ________________________________ Date Signed: ______________________

THIS AUTHORIZATION EXPIRES ON __________ OR UNTIL I REVOKE IT.

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TELEPHONE MESSAGE AUTHORIZATION FORM

FULL NAME: ____

I CAN BE REACHED AT THE FOLLOWING NUMBER(S):

HOME: ____________________ CELL: ____________________

EMAIL: ____

I HEREBY AUTHORIZE YANGTZE MEDICAL CENTER AND ITS STAFF TO LEAVE MESSAGES (RECORDED OR WITH ANY AVAILABLE PARTY) ON THE ABOVE PHONE NUMBER(S) AND EMAIL ADDRESS REGARDING APPOINTMENT REMINDERS AND MEDICAL INFORMATION PERTAINING TO MYSELF.

SIGNATURE: ____

DATE: ____