Peter Sheng, M.D.

	PATIENT	SPOUSE/GUARDIAN
NAME		
ADDRESS		
HOME PHONE	( )-	( )-
CELL PHONE	( )-	( )-
BIRTHDATE		
EMPLOYER		
WORK PHONE		
OCCUPATION		

MARITAL STATUS __MARRIED __SINGLE __DIVORCED __WIDOWED

SEX __ FEMALE __MALE

EMERGENCY CONTACT _____
NAME RELATIONSHIP PHONE NUMBER

REFERRING PHYSICIAN_____ PHONE _____

PRIMARY PHYSICIAN_____ PHONE_____

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION
TO TWO FAMILY MEMBERS

I HEREBY CONSENT TO THE RELEASE OF MY TREATMENT PLAN, TEST RESULTS AND ANY MEDICAL INFORMATION TO TWO FAMILY MEMBERS:

Contact #1_____ _____ _____
Name Relationship Phone number

Contact #2_____ _____ _____
Name Relationship Phone number

ACUPUNCTURE FINANCIAL GUARANTEE

This office will not file insurance claims for any self pay acupuncture treatments and herbs prescribed by Dr. Sheng. It is the patient's responsibility to pay at time of service. This office will provide proof of treatments for patients if needed.
I unconditionally guarantee the payment to this office of the total amount due at time of treatment. There will be a $15.00service charge for every returned check.

_____ _____ _____
Signature of responsible party Date Relationship to Patient