PATIENT INFORMATION

NAME _____ HOME PHONE _____

ADDRESS _____ CITY _____ ZIP _____

AGE _____ DATE OF BIRTH _____ HEIGHT _____ WEIGHT _____

SOC.SEC. NUMBER _____ MARRIED ? _____ # CHILDREN _____

EMPLOYER _____ WORK PHONE _____

INSURANCE CARRIER _____

HOW DID YOU HEAR ABOUT DR. CHUNG?

DR. REFERRAL _____ FRIEND _____ YELLOW PAGES ____ NEWSPAPER ____
(PLEASE NAME) (PLEASE NAME)

MAIN PROBLEM : _____

_____

_____

CAUSE: _____ ONSET _____

IS YOUR CONDITION GETTING WORSE? YES ___ NO ___ CONSTANT __ COMES & GOES ___

HAVE YOU SEEN OTHER DRS FOR YOUR CONDITION ? YES _____ NO _____

IF YES, PLEASE LIST THE APPROPRIATE DRS. AND APPROX. DATE OF LAST EXAM

DOCTOR _____ DATE _____

DOCTOR _____ DATE _____

MEDICATIONS TAKEN WITHIN THE LAST TWO MONTHS: _____

_____

ALLERGIES: _____

LIST ANY OPERATIONS YOU HAVE HAD AND APPROXIMATE DATE:

_____ DATE _____

_____ DATE _____

_____ DATE _____

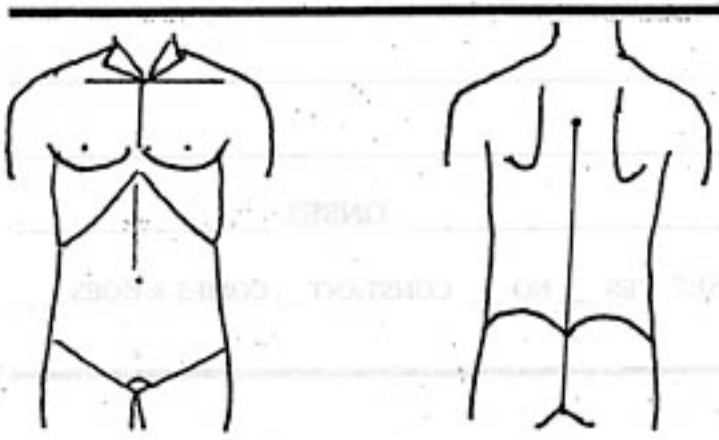
FAMILY HISTORY:

CANCER ____ DIABETES ____ HIGH BLOOD PRESSURE ____ ALLERGIES ____ ALCOHOLISM ____

HEART DISEASE ____ ASTHMA ____ OTHER _____

OTHER CONCURRENT THERAPIES: _____

_____



I hereby release The Acupuncture, Internal Medicine & Pain Clinic LLC., Dr. J.B. Chung and all employees from liability for loss, damage, or injury to my person resulting from, arising in connection with, or related in any way to treatment provided by him. I understand that Dr. Chung makes no guarantee but will use his knowledge and skill to the best of his ability to effect a cure. In return for this release, I will receive such treatment as is determined by Dr. Chung to be appropriate.

I also understand that Health Insurance and Workmen's Compensation do not always pay for Acupuncture treatment. They may totally deny or may pay only a portion of the charge. I agree that all charges incurred are my responsibility whether or not my insurance or workmen's compensation pays all or only a portion of my balance.

NAME: _____ DATE: _____