

Lynn Maloney

ACUPUNCTURE

Using your body's intelligence to heal.

Patient Information Sheet CONFIDENTIAL

Today's Date: ____/____/____

Date of Birth: ____/____/____

Full Name: _____ Nickname: _____

Address: Street _____ City _____

State _____ Zip Code _____

Phone: (Cell) _____ (Home) _____ (Work) _____

Primary Care Doctor: _____

Other Care Providers (physicians, massage therapists, chiropractors, psychotherapists)

- 1) _____
- 2) _____
- 3) _____

Do I have your permission to confer with your other health care practitioners? **YES / NO** (Circle one)

How did you hear about Lynn Maloney Acupuncture? _____

How did you make your appointment?

___ **On the phone**

___ **Online scheduling system (Schedulicity)**

___ **In person**

Email (will not be used by other businesses) _____

Would you like to receive our e-mail newsletter? **YES NO**

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