# Dr. Lorri Beauchamp, L.Ac. DOM

Name: _____Date of Birth: _____ Gender: _____ Height: _____
Weight: _____ Marital Status: ____ Race/Ethnicity: _____

Street Address: _____ City: _____
State: _____ Zip Code: _____
Phone:_____/_____Email:_____

Emergency Contact Name: _____ Phone: _____

HEALTH INFORMATION (Please include any necessary documentation)

Primary Doctor: _____ Specialist: _____

Chief Complaint: _____

Secondary Complaints: _____

MedicalConditions:_____
_____

Hospitalizations/Surgeries/Implants:_____
_____
_____

Medications,VitaminsSupplements_____
_____
_____

Allergies: _____

Are you pregnant? ☐Yes ☐No ☐Unsure Date of Last Menstrual Cycle:_____

ADDITIONAL INFORMATION If there is anything else that you feel is relevant to the successful outcome of your treatment that was not listed above, please detail it here (this may include job or familial obligations, stress levels, sleep patterns, eating preferences etc. or anything else that may be a concern regardinghealth):_____
_____
_____
_____
_____
_____
_____

By signing below, I affirm that I have provided true and accurate information to the best of my knowledge.

Patient's Signature: _____ Date: _____

Consent for Treatment Dr. Lorri Beauchamp,DOM

I hereby request and consent to performance of acupuncture treatments and other procedures within the scope of practice of acupuncture by Dr. Lorri Beauchamp, DOM or other licensed acupuncturist who now or in the future will treat me while employed by, associated or assigned by Dr. Beauchamp.

I understand that the treatment includes but not limited to acupuncture, acupuncture injection therapy, moxibustion, cupping, gua-sha, electrical stimulation, tui-Na, Oriental herbal medicine, nutritional supplementation and counseling.

I have been informed acupuncture and its adjunct therapies are generally safe methods of treatment but there may be some side effects such as bruising, numbness or tingling near needling sites, or dizziness. Rare and unusual side effects may include nerve damage, or organ puncture (such as pneumothorax), burning, scarring, or infection. Herbs and nutritional supplements that may be recommended and are generally considered safe, although some substances may be toxic in large doses. Possible side effects may include nausea, gas, vomiting, headache, diarrhea, high risk, and healing of the tongue. I agree to immediately notify a member of the clinical staff if any unanticipated or unpleasant side effects associated with herbs occur.

I hereby request and consent to their performance of acupuncture injection therapy (AIT) treatments and related procedures within the scope of practice of acupuncture. I understand AIT is generally a safe method of treatment but it may have some side effects such as ones listed above. Additional possible adverse reactions to homeopathic and nutritional supplements (including B-12) may cause an allergic reaction. If allergic reaction or anaphylaxis occurs, I agree to seek allopathic emergency care immediately.

I do not expect the clinical staff to be able to dissipate and explain all possible risk and complications of treatment. I wish to rely on the staff to exercise judgment during treatment which they believe at that time, based upon the facts been known, is in my best interest.

I understand the clinical and administrative staff may review my patient records including lab reports. All records will be kept confidential and will not be released without my written consent.

By voluntary signing below I show that I have read, or been read to, the above consent to treatment, have been told about the risk and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. I intend for this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment.

_____

Patient Signature Date

Office Signature Date

Dr. Lorri Beauchamp, DOM, LAC

# Insurance Verification Form

Insurance Company Name* _____

Insurance Company Phone Number* _____

Patient's Name* _____

Insurance ID Number* _____

Patient's Group Number _____

Patient's Date of Birth* _____

Patient's Email Address* _____

Patient's Phone Number* _____

Which of our locations is more convenient for you?

☐ Hollywood, FL

☐ Kalamazoo, MI