Five Element Acupuncture
Homer LLC

Patient Information			
Last Name:		First Name (Legal):	MI:
Preferred Name:	DOB:	Today's Date:	
Street Address: Zip Code:		City, State:	
Phone:		Email:	
Occupation:		How did you hear about me?	

Emergency Contact	
Who could we contact in case of an emergency?	
Their relationship to you?	Their phone number:
Please list any known allergies:	

Communication Consent	
Preferred method(s) of communication: ☐ Text ☐ Call ☐ Email	Would you like to receive appointment reminders? ☐ Text ☐ Email
With my signature below, I give **Five Element Acupuncture Homer LLC** permission to contact me via my selected method(s) above for the purpose of appointment reminders, scheduling changes, or general communication regarding my care. I understand that text and email correspondence are **not guaranteed** to be HIPAA Privacy Rule–compliant, and I accept the risks associated with these methods if selected.	

Patient Signature:	Date:
Responsible Party (if different than patient):	Date: