



Michigan Associates of
Acupuncture and
Integrative Medicine

Registration Form

Welcome to Michigan Associates of Acupuncture and Integrative Medicine

Please take a moment to provide us with some information about yourself and your health conditions so we may do our best to treat you.

Name _____

Home Phone # _____ Cell Phone # _____

Please indicate with a * which phone # you prefer us calling to confirm apts, etc...

Address _____

City _____ State _____ Zip _____

Sex : M F Age _____ Birth Date _____

Occupation _____

Patient Employed by _____

Business Address _____

Business Phone Number _____

E-Mail Address _____

In case of an emergency, whom should we contact?

Name _____ Phone # _____ Relation _____

Whom may we thank for referring you? _____

I understand that I should be evaluated by a physician for the condition I am requesting consultation. The treatment I am being given at Michigan Associates of Acupuncture and Integrative Medicine does not constitute a western medicine diagnosis. I understand that I am financially responsible for all charges. Furthermore, I understand that payment is due at the time of service and that cancellations made less than 24 hours will be charged the full rate for service.

Responsible Party

Date

7001 Orchard Lake Road, Suite 120
West Bloomfield, MI 48322
248 | 737 | 7126