Anita Chen Marshall, DAOM, Pharm.D, L.Ac.

Sequoia Healing Center
2766 Sea View Parkway
Alameda, CA. 94502
510-523-10

Patient Registration Form

(Please print clearly)

Name:____ Date:__________________

Address:_________________________________ City:___________ Zip Code:_________

Home Phone:__________________________ Work Phone:_________________________

Cell/Mobile Phone:______________________ Fax Number: _________________________

E-mail Address:____

Age:_____ Date of Birth:_______________ Driver License #:________________________

Employer:______________________________ Occupation:_________________________

Work Address:____________________________ City:___________ Zip Code:_________

Insurance Carrier:__________________________ Membership #:___________________

Name of Spouse/Partner:__________________________ Daytime Phone #:______________

Employer:______________________________ Occupation:_________________________

Number of Children: ______________________ Ages:_____________________________

Contact Person, in case of emergency:____________________ Phone:___________________

Name of Primary care Physician:________________________ Phone:_________________

Address:______________________________ City:__________ Zip code:______________

Have you ever been treated with Acupuncture or Chinese Herbal Medicine before? __________

If Yes, when and for what reason? ____

Who referred you to this office? ____