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PATIENT INTAKE FORM

Name: _____ Date: _____

Age: _____ Sex: _____ Date of Birth: _____

Address: _____ City: _____ Zip: _____

Day Phone: _____ Evening Phone: _____ Cell Phone: _____

Work Phone: _____ E-Mail: _____

- Married
- Divorced
- Widowed
- Single
- Separated

Occupation: _____

Employer: _____

Address: _____

Reason for your appointment today: _____

In Case of Emergency, Please Notify: _____ Phone: _____

Payment Information: Credit Card #: _____ Expiration Date: _____

3 digit code on the back of card: _____

- VISA
- Mastercard

Insurance Provider: _____ Subscriber ID _____

How did you hear about us?

- Referral Who referred you to our clinic? _____
- Internet If so, which website? _____
- Lecture
- Conference or Health Expo
- Other Please explain: _____