

Dr. Huang

Chinese Medicine & Acupuncture Clinic Confidential Patient's Registration Form

Date: _____

First Name: _____

Surname: _____

Date of Birth: __ / __ / ____

Gender: Male/Female

Home Address:

Telephone: _____

Profession: _____

Any previous serious illness or allergy? Please indicate:

Are you pregnant? Yes/No. How many month? __ Months.

Current illness/conditions for consultation:

Signature: _____