



The Center For Reproductive Healing

Patient Information

CONFIDENTIAL

The Center for Reproductive Healing □ 44 W. Market Street □ Marietta, PA 17547
www.ReproductiveHealing.com

Phone: 1-877-619-2006

Welcome to The Center for Reproductive Healing

Please take a moment to provide us with some information about yourself and your health conditions so that we may do our best to treat you. The Center for Reproductive Healing considers this information privileged physician/patient communication and will hold it in confidence.

NAME (LAST, FIRST, MIDDLE)	DATE
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AGE	DATE OF BIRTH	SEX <input type="checkbox"/> Male <input type="checkbox"/> Female	MARITAL STATUS <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed
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PHONE	EMAIL ADDRESS
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HOME ADDRESS		
CITY	STATE	ZIP

OCCUPATION

EMPLOYED BY

EMPLOYERS ADDRESS		
CITY	STATE	ZIP

SOCIAL SECURITY NUMBER	DRIVER'S LICENSE NUMBER
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SPOUSE'S NAME

CONTACT IN CASE OF AN EMERGENCY	RELATIONSHIP	PHONE
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ADDITIONAL INFORMATION / NOTES

I understand that I should be evaluated by a physician for the condition for which I am requesting consultation. I understand that treatments through The Center for Reproductive Healing are based upon Traditional Chinese Medical treatments, including Chinese herbal therapy, and that a Traditional Chinese Medical diagnosis does not necessarily replace a Western Medical diagnosis. I am responsible for my own health, which includes seeking out health care options that are appropriate for the condition for which I am seeking treatment. If no substantial improvement is made in the condition for which I am seeking consultation, I am to seek advice from a Western medical doctor.

Finally, I know that I am free to incorporate the advice of a Western medical doctor into my healthcare regimen, and if I do so, is my responsibility to advise my physician of any herbal supplements I am concurrently taking.

SIGNATURE

DATE