



harmony  
traditional chinese medicine  
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### Patient Registration Information

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

#### Personal Information:

Name (Last, First, M.I.): \_\_\_\_\_  
Street Address: \_\_\_\_\_  
City, State, Zip: \_\_\_\_\_  
Home phone: \_\_\_\_\_ Work: \_\_\_\_\_  
Cell: \_\_\_\_\_ E-Mail: \_\_\_\_\_  
Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex: M \_\_\_\_ F \_\_\_\_  
Employer / Name of School: \_\_\_\_\_

Is your condition the result of a work injury? Y \_\_\_\_ N \_\_\_\_  
auto accident? Y \_\_\_\_ N \_\_\_\_

Spouse's Name (Last, First, M.I.): \_\_\_\_\_  
How do you wish to be addressed? \_\_\_\_\_

#### Referral information:

How were you referred to this office? \_\_\_\_\_  
\_\_\_\_\_

#### Emergency Contact

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Home phone: \_\_\_\_\_ Work/Cell: \_\_\_\_\_  
Street Address: \_\_\_\_\_  
City, State, Zip: \_\_\_\_\_