OAK STREET CHIROPRACTIC CARE, LTD.

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New Patient Confidential Information

The following information is needed for our files so we can better serve you as a patient. Please fill in all portions of the form. If you need any help, please ask. Thanks!

Patient Information

First Name: _____Last Name: _____SS#:_____-_____-_____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: (____)_____ Cellular: (____)_____ Work Phone: (____)_____

Birth Date: _____ Age: _____ Marital Status: _____ Number of Children: _____

E-mail: Business: _____ Personal: _____

Employer: _____ Occupation: _____

Spouse's First Name: _____Last Name: _____SS#:_____-_____-_____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: (____) _____ Cellular: (____) _____ Work Phone: (____) _____

Birth Date: _____ Age: _____ Number of Children:_____

Employer: _____Occupation: _____

Emergency Contact: Name: _____ Phone: (____) _____

Insurance Information

Primary Insurance:

Insurance Company: _____

Address: _____

_____

Phone: (___) _____

Secondary Insurance:

Insurance Company: _____

Address: _____

_____

Phone: (___) _____

ID number: _____

Group number: _____

Effective Date: _____

Insurance Type: PPO EPO HMO (referral #_____)

ID number: _____

Group number: _____

Effective Date: _____

Insurance Type: PPO EPO HMO (referral #_____)

Cancellation Policy

We understand the occasional need to cancel; however, we do ask for a **24-hour advanced notice**. A **$100.00 fee** will be charged to your credit card or account for any cancellation made without 24-hour notice. This fee is not payable by your insurance company. **I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I understand, and authorize, this office to prepare any necessary reports and forms, including my medical records to assist me in making collection from the insurance company. Additionally, I understand that any amount authorized will be paid directly to this office, and that all services rendered to me are charged directly and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will immediately due and payable.

Patient's Signature: _____ Date: _____

Guardian's Signature: _____ Date: _____