

NEW PATIENT INFORMATION

Thank you for choosing American Integrated Chiropractic for your health and wellness needs.

Patient's Name (PRINT)	S.S.#	Date of Birth		
Age	Sex	Marital Status	# Children	Home Phone #
Address	City & State	Zip		
Work #	Cell #	Fax #		
E-mail Address	Would you like to receive our e-newsletter? Yes / No (Circle)			
Employer	Occupation	Part Time / Full Time (Circle)		
Patient Driver's License #	State	Referred by		
Emergency Contact	Emergency Phone			

Personal Insurance Info:

Please provide a copy of your card for our records

Were You Injured on the Job? Yes / No (Circle)	Worker's Comp Carrier	Claim #
Employer at Time of Injury	Employer's Phone #	
Were You Injured in an Automobile Accident? Yes / No (Circle)	Date of Accident	Claim #
Auto Insurance Name/Address	Ins. Phone #	
Attorney's Name	Attorney's Phone #	

I understand that I am directly and fully responsible at all times for payment to American Integrated Chiropractic (AIC) for all services and supplies rendered to me, unless my case is an accepted Oregon Worker's Compensation or Auto claim. AIC makes no guarantee regarding insurance eligibility, coverage and/or claim reimbursement. All accounts are due and payable on the date of service regardless of claim status unless other arrangements have been made in writing in advance. **Please note: We reserve the right to assess a \$55.00 office visit charge for all appointments cancelled or missed without 24-hour notice.** A \$25.00 fee will be assessed for any returned check. Interest of 18% per annum will be charged to all overdue accounts. Should collection services be required, a fee of 25% of the account balance will be added to the account balance.

I hereby authorize this office to release any information requested by my insurance company to document my claim eligibility. By signing this form, I indicate that I have read and understand AIC's new patient policy.

Signature _____ Date _____