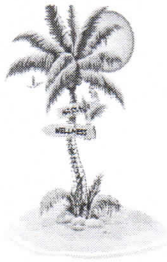


Oasis Chiropractic & *Wellness, Inc.*

8980 S Us HWY 1 Suite # 104
Port St. Lucie, FL, 34952
PH: (772) 336-8600 FAX: (772) 464-9978

Last: ______________________ First: ______________________ MI: ______
DOB: ______/______/______ SSN: ______________________
Street: ____
City: ______________________ State: __________ Zip: __________
Cell # (_____) ______________ Home # (_____) ______________
Email: ____

How often do you experience your symptoms?

a) Constant (76-100% of the day)
b) Frequently (51-75% of the day)
c) Occasionally (26-50% of the day)
d) Intermittently (0-25 % of the day)

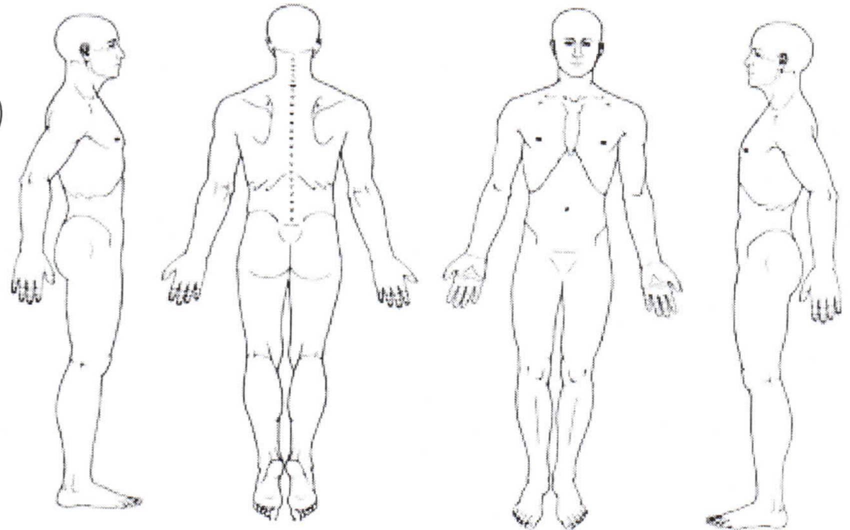
What describes the nature of your symptoms?

a) Sharp
b) Dull Ache
c) Numb
d) Shooting
e) Burning
f) Tingling

How are your symptoms changing?

a) Getting better
b) Not Changing
c) Getting worse

Indicate where you have pain or symptoms



None — Unbearable
(0) (1) (2) (3) (4) (5) (6) (7) (8) (9) (10)

I authorize release of any and all information of my insurance companies and/or Medicare and permit a copy of this authorization to be used in place of the original. I authorize my doctor to act as my agent to assist in obtaining my payment from my insurance company and authorize payment directly to my physician or to the party who accepts assignment.

I understand that I am responsible for my billing including co-payments and deductibles. In the event of non-coverage, I agree to assume responsibility of payment if my insurance/Medicare is denied.

Patient Signature: ______________________________ Date: __________