Patient Information

ADVANCED HEALING
ACUPUNCTURE - MASSAGE - NUTRITION

10330 SE 32nd Ave. Suite 120
Milwaukie, OR 97222
503-659-8900
www.advancedhealingpdx.com

Last Name: _____ First Name: _____ Preferred Name:_____

Date of Birth: _____ /_____ /_____(month/day/year)

Home Address: _____

City:_____ State:_____ Zip Code:_____

Primary Phone: _____ HOME CELL WORK (circle one)

Secondary Phone:_____ ____ HOME CELL WORK (circle one)

Email address: _____

□ Check if you would NOT like to receive our monthly newsletter with special discounts, health tips, and fun events

Marital Status: □Single □Married □Separated □Divorced □Widowed

How did you hear about us? (Please specify location or person's name so we can thank them)

□Personal Referral _____ □Medical Referral_____

□Internet Search _____ □Other _____

Name/Location of your Primary Care Physician: _____

What is your job title? _____ Name of Employer: _____

In case of emergency, contact _____ Phone: _____

Charges are due and payable at the time of treatment unless confirmation of insurance coverage has been received. Insurance co-payments are due at time of treatment.

Appointments missed or cancelled with less than 24 hours notice will incur a $40 fee

The above is true, understood and agreed.

Signature_____ Date_____

Insurance Information (if applicable)

Policy Holder_____ Relationship to Patient_____

Health Insurance Company _____Business Phone_____

Address_____

City_____ State_____ Zip Code _____

Policy #_____ Group #_____ Effective Date_____

MVA/Workers Comp Information (if applicable)

Insurance Company_____ Policy #_____

Date of Injury _____ /_____ /_____(day/month/year) Claim # _____

I hereby assign Advanced Healing (PJG Enterprises Inc.), any medical Benefits for services rendered by them to which I am entitled. I authorize the release of any medical or other information necessary to process claims for those services. I understand that I am responsible for any charges not covered by my insurance.

Signature_____ Date_____