OXYGENOASIS
A Center for Healing

PATIENT INFORMATION SHEET

Name:	*Social Security Number:*

Date of Birth:	*Age:*	*Marital Status (circle one):*
		Single Married Divorced Widowed

Address:

Home Telephone Number:	*Secondary Number:*	*Cellular Number:*

Email:	*Employer's Name:*

Employer's Address:

Employer's Telephone Number:	*Primary Physician:*	*Referring Physician*

Emergency Contact:	*Contacts Relationship:*	*Contacts Telephone Number:*

Primary Insurance:	*Secondary Insurance:*	*Case Managers Number:*

Guarantor:	*How Did you find out about us (circle all that apply):*
	Facebook Twitter YouTube LinkedIn Pinterest TV Internet Website Podcast/Radio Friend/Family Physician

I authorize consultative services and related treatment by **OXYGEN OASIS HYPERBARIC WELLNESS CENTER**, **Oxygen Therapurity**, and its agents along with the releases of any necessary medical information needed in my care, or in the processing of medical claims to **OXYGEN OASIS HYPERBARIC WELLNESS CENTER**, and **Oxygen Therapurity**. I also request the payment of medical benefits for the care and services provided to **OXYGEN OASIS HYPERBARIC WELLNESS CENTER**, this **FACILITY**, **Oxygen Therapurity**, and its agents.

*I understand and agree to be responsible for the balance on my account for any professional/technical services rendered by **OXYGEN OASIS HYPERBARIC WELLNESS CENTER** , this **FACILITY** , **Oxygen Therapurity** and its agents. I certify that the information provided is true and correct to the best of my knowledge. I will notify **OXYGEN OASIS HYPERBARIC WELLNESS CENTER** , Oxygen Therapurity and its agents of any changes in the above information*

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(Signature of Patient) *(Date)*

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(Witness) *(Date)*