Is your case: □ Workers Compensation □ No Fault □ Personal Injury

Date of Injury: \_\_\_\_/\_\_\_\_/\_\_\_\_ Time: \_\_\_\_\_\_\_\_\_ Location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please describe how your injury happened: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Did you report your injury? □ No □ Yes – To whom? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Were you hospitalized? □ No □ Yes – Where? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

By ambulance? □ No □ Yes Were x-rays taken? □ No □ Yes

Date(s) of hospitalization: \_\_\_\_\_\_\_\_\_\_\_\_ Medication(s) prescribed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you presently working? □ No □ Yes – Dates of time lost from work: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you been treated by any other Chiropractor or physician for this injury? □ No □ Yes

If yes, Doctor’s name and specialty: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**COMMUNICATION CHANNELS**

*To help us better explain your Chiropractic condition and how we may be able to best help you, please check the best answer.*

I remember important things in my life by

□ What I see □ What I hear □ What I feel

The primary reason I brush my teeth is to

□ Avoid tooth decay and gum disease □ Make sure I have healthy teeth and gums

When I make decisions I generally

□ Gather facts and weight the evidence □ Make the right choice instantly

□ Consult my friends and family □ Depend on how I ‘feel’ about it

**INSURANCE INFORMATION**

Do you have health insurance? □ No □ Yes – if yes, please continue

Insurance Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Group Number: \_\_\_\_\_\_\_\_\_\_\_ Member ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ins. Phone Number: \_\_\_\_ - \_\_\_\_ - \_\_\_\_\_\_\_\_

Are you covered by any additional insurance? □ No □ Yes – if yes, please continue

Policy holder’s name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB (MM/DD/YY): \_\_\_\_/\_\_\_\_/\_\_\_\_

Insurance Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Group Number: \_\_\_\_\_\_\_\_\_\_\_ Member ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ins. Phone Number: \_\_\_\_ - \_\_\_\_ - \_\_\_\_\_\_\_\_

Payment acknowledgment (please sign). I understand and agree that health and accident insurance policies are an arrangement between insurance carrier and myself. I also understand that this office will prepare any forms and reports necessary to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account on my receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care treatment, any fees for professional services rendered to me or my dependent will be immediately due and payable.

**Patient’s Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_

**Insured’s Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_