WORKERS' COMPENSATION

PATIENT INFORMATION

Date: ______________

First Name: ______________________________ Last Name: ________________________

Address: _________________________________
City/State: ________________________________ Zip Code: __________

Social Security #: ____________________ DOB: ___________ AGE: _______

Sex (circle) MALE / FEMALE
# of Children ______ Marital Status: S M D W Spouses Name: ___________________________

Contact Information:
Home # : ________________ Cell # : _______________________
Work # : ________________ Email Adress : ___________________________

In Case of Emergency Contact : ____________________________ Phone # : ___________

Employer : ________________________________ Occupation: ______________________________
Work Address : ____________________________ Phone #: ____________________
Are you currently working? ______________
How were you referred to the office? ______________________________
Is your injury work related? ____________________ Was the accident reported? ________________
Is your injury related to an Automible Accident? ____________________

Main Complaint: ____
Secondary Complaint: ____

Have you ever seen another doctor for this complaint? __________________________
If YES what is the doctors name? ____

PRIMARY DOCTORS NAME: ____________________ Phone: _______________________

MEDICAL HISTORY

(Please Check if Applicable)

Do you have concerns about your current weight? ________ YES ________ NO

- ☐ Pregnant
- ☐ Diabetes
- ☐ TMJ
- ☐ Epilepsy/Seizures
- ☐ Cancer
- ☐ Lymphendema
- ☐ Stroke
- ☐ Arthritis
- ☐ Dizziness
- ☐ Broken/Fractures Bones
- ☐ Headaches
- ☐ High Blood Pressure
- ☐ OTHER

Please Explain: ____________________

SURGICAL HISTORY

(Please Check if Applicable)

- ☐ Pacemaker
- ☐ Metal/Plastic Implants
- ☐ Joint Replacement

Any Surgical Procedures: ____________________

List any Drugs, Medications, or herbal Supplements you are currently taking:

____

INSURANCE INFORMATION

Do you have health insurance? Yes or No (circle)

Name of Insurance Company: ____________________

Address: ____________________

Adjuster's Name: ____________ Phone # : ____________ Ext: ________

WCB # : ____________ Carrier Case # : ____________

PAYMENT INFORMATION :

I understand and agree that Health and accident insurance policies are an arrangement between an insurance carrier and me. 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 an amount authorized to be paid directly to the office will be credited to my account on receipt. However I clearly understand and agree that all services rendered to me are charged directly to me and I am personally responsible for payment. I also understand that if I suspend

I affirm that the above information is correct to the best of my knowledge.

Patient Signature: ______________________________ Date: ____________

Insured Signature: ______________________________ Date: ____________

Parent, Spouse, or Guardian Signature: ______________________________ Date: ____________