



Name: _____ Date: ____/____/____

Address: _____

Street

City

State

Zip Code

Preferred Contact Number: (____) _____ - _____

This number is a: Home ___ Cell ___ Other ___

Email Address: _____

*Concord Chiropractic will not use your e-mail address for anything other than appointment reminders or newsletters

Date of Birth: ____ - ____ - ____ Age: _____

Occupation: _____ Employer's Name: _____

Reason for visit: _____

Who may we thank for referring you to our office? _____

Date of accident: _____ State of accident: _____

Insurance Name: _____ Claim Number: _____

Claims address: _____

Adjuster Name: _____ Adjuster Phone: _____

Law Firm Name: _____

Attorney Name: _____ Attorney Phone: _____



Worker's Compensation Questionnaire

Patient Name: (print) _____

Employer's name & address:

Phone number: _____

Type of business (retail, manufacturing, construction, etc.) _____

Workers Compensation Insurance Carrier: _____

On what date did your injury occur? _____ What time? _____ ☐ AM ☐ PM

What address were you at when you were injured? _____

Did you notify your employer of this injury? ☐ Yes ☐ No

Have you retained an attorney? ☐ Yes ☐ No

If Yes, please give name & address: _____

Are you currently in litigation for this injury? ☐ Yes ☐ No ☐ Maybe

Please explain how the injury or illness occurred: _____

What injuries did you suffer? _____

When was the last day you worked? _____

When did you return to work? _____

When was your first examination? _____

Who examined you? _____

Check one, if known: ☐ D.C. ☐ M.D. ☐ D.O. ☐ D.D.S.

What was doctor's diagnosis? _____

Have you received any treatments prior to visiting this office? ☐ Yes ☐ No

What treatments did you receive? _____

Have you ever injured this area before? ☐ Yes ☐ No

If Yes, when did the injury occur? _____

Did you lose time from work? ☐ Yes ☐ No

If you lost time from work with injuries prior to this injury, please list doctor or doctors consulted:

Do you have other injuries or illnesses that affect your employment? ☐ Yes ☐ No

If Yes, please explain: _____

In your work, do you favor one part of your body more than others? ☐ Yes ☐ No

If Yes, please explain: _____

Do you have a history of absenteeism caused from accidents on the job? ☐ Yes ☐ No

Have you ever had a Worker's Compensation claim before? ☐ Yes ☐ No

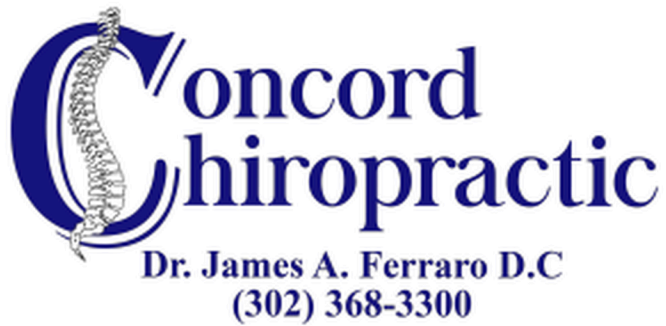
Before the injury, were you capable of working on an equal basis with other employees of the same age? ☐ Yes ☐ No

Are your work activities restricted as a result of this accident? ☐ Yes ☐ No

Since this injury are your symptoms: ☐ improving? ☐ getting worse? ☐ staying the same?

The statements made on this form are accurate to the best of my knowledge, and I agree to let this office and its doctors examine me for further evaluation.

X _____ Date: ____/____/____
Patient Signature



INFORMED CONSENT

I have received information about my condition and proposed chiropractic treatment program as well as alternative courses of care, the benefits, the risks, and the side effects of the treatment and the consequences of not having the proposed treatment.

I understand and am informed that, as in all health care, in the practice of chiropractic there are some rare risks to treatment, including but not limited to, muscle strain and sprain, fracture, dislocation, disc injuries, temporary exacerbation of symptoms, and altered blood flow to the head and brain.

My doctor has responded to all my requests for information about the proposed treatment. I have read or have had read to me the above consent. I have also had the opportunity to ask questions about its content. By signing below, I consent to chiropractic treatment.

Print Patient's Name

Signature of Patient

Date

Print Parent/Guardian Name

Signature of Parent/Guardian

Date

Print Witness Name

Signature of Witness

Date



Authorization Form

Patient Name: (print) _____

RELEASE OF INFORMATION

I hereby authorize Concord Chiropractic to release medical and financial data to my insurance carriers, other medical facilities, and attorney(s).

Initials: _____

RESPONSIBILITY OF BILL

The undersigned hereby accepts full financial responsibility for charges and services rendered. The undersigned understands that services are rendered and charged to you (the patient) and not your insurance company. Concord Chiropractic does not accept total responsibility for collecting an insurance claim or negotiating a disputed settlement. It is the financial obligation of the undersigned to be responsible for any charges or services not covered by insurance for which payment is denied through any utilization review or pre-certification procedures, or any remaining balance upon completion of settlement. The undersigned also agrees that this obligation shall exist regardless of private contractual agreement between the patient and any insurance carrier, attorney, or third party not signing this agreement.

Initials: _____

CONSENT FOR TREATMENT OF A MINOR CHILD

Consent is hereby given by the undersigned for Chiropractic treatment, X-Rays, Acupuncture, any diagnostic studies as ordered by the doctors, and therapies (therapeutic massage, electrical stimulation, ice/heat therapy, hydrotherapy, therapeutic exercises) performed by the technical staff of Concord Chiropractic. The undersigned states that he/she is the patient's legal guardian.

Initials: _____

AUTHORIZATION FOR PAYMENT OF INSURANCE BENEFITS TO PROVIDER

I hereby irrevocably authorize payments of my medical benefits otherwise payable to me to be made payable and mailed directly to Concord Chiropractic for professional services rendered. No other third party, including my attorney, should receive payment of my bills except this office for the remainder of this claim. It will be assumed and relied upon that the insurance carrier has agreed to and acknowledged medical coverage and will send payments directly to this office.

Initials: _____

X _____

Patient or Guardian Signature

Relationship to Patient

Date _____



Release of Medical Records

Patient Name (please print): _____

Date of Birth: ____/____/____

I hereby authorize _____ to release all medical records, or those concerning the dates of treatment on _____, to:

**Concord Chiropractic
20 A Trolley Square
Wilmington, DE 19806**

These records are requested for the purpose of Medical Care. Documents requested should include:

- Discharge Summary
- History and Physical
- Operative Record
- Physician Progress Notes
- Diagnostic Tests and X-ray reports
- Other _____

I understand that this request for release of information stands effective for 120 days. This request may be revoked at any time but is not retroactive for requests that have been complied within good faith. This authorization may be revoked by written request to an authorized representative of Concord Chiropractic.

X _____ /____/____
Patient's Signature Date

X _____ /____/____
Signature of Legal Guardian Relationship to Patient Date

Disclosure of specific information for release is limited to the above mentioned recipient only. Federal regulation, 42 CFR Part 2, prohibits the redisclosure of the enclosed information unless the consent expressly permits further disclosure or the redisclosure is otherwise permitted under regulations.