BOLTON CHIROPRACTIC

563 Main St., Bolton, MA 01740

WELCOME TO OUR OFFICE!! THANK YOU FOR GIVING US THE PRIVILEGE OF HELPING YOU.

IF YOU NEED MORE SPACE, WRITE ON THE BACK OF THIS PAGE

YOUR FULL LEGAL NAME _____ NICK NAME _____
WHO/WHAT REFERRED YOU TO OUR OFFICE? _____
ADDRESS _____ STATE _____ ZIP _____
DATE OF BIRTH _____ SEX ___ MARITAL STATUS _____ SOCIAL SECURITY #_____
E-MAIL ADDRESS _____
PHONES: HOME _____ WORK _____ CELL _____
OCCUPATION _____ FULL OR PART TIME _____ EMPLOYER _____
EMPLOYER'S ADDRESS_____
WHAT IS YOUR PROBLEM OR COMPLAINT? _____
_____
WHEN DID IT START _____ IS THIS THE FIRST TIME? _____
IF NO, WHEN WAS THE FIRST TIME_____
IS THIS PROBLEM DUE TO EITHER A WORK OR CAR ACCIDENT? Y N IF YES, WHICH ?: _____
HOW DID TODAY'S COMPLAINT START? (PLEASE DESCRIBE IN DETAIL) _____
_____
DESCRIBE ANY SERIOUS ILLNESSES, SURGERIES, &/OR ACCIDENTS AND DATES THEY OCCURRED:
_____
_____
HAVE YOU EVER HAD CHIROPRACTIC CARE BEFORE? _____ IF YES, WHY? _____
NAME OF SPOUSE _____ # OF CHILDREN: BOYS _____ GIRLS _____
PLEASE LIST ALL ACTIVITIES THAT YOU CAN NOT DO AS A RESULT OF YOUR CONDITION:
_____
DUE TO YOUR ACCIDENT OR ILLNESS, WERE YOU TOTALLY DISABLED? _____ FROM WHEN TO WHEN? _____ WERE YOU HOSPITALIZED? _____ WHAT WERE THE DATES OF HOSPITALIZATION? _____
LIST THE VITAMINS AND MEDICATIONS YOU NOW TAKE: _____
_____
INSURANCE COMPANY _____ PHONE # _____ FAX # _____
INSURANCE ADDRESS _____ IDENT.# or POLICY# _____
IF ANYONE ELSE IS LEGALLY/FINANCIALLY RESPONSIBLE FOR YOU, GIVE THEIR NAME AND ADDRESS:_____
FOR WOMEN: ARE YOU PREGNANT? _____ IF YES, DUE DATE _____

To the best of my knowledge, all information above is accurate and true. I authorize my insurance carrier(s), trustees, executors, accountant, custodian &/or attorney to make payment directly to Richard Waller, Jr., D.C. for services rendered to me/my family by Richard Waller, Jr., D.C.. I agree to pay any balance left unpaid. I authorize Richard Waller, Jr., D.C. to send bills/claims &/or reports for services rendered directly to my insurance carrier &/or attorney and to release to my insurance carrier &/or attorney any information needed to process my claim. I acknowledge that I am completely and fully responsible for paying all fees that I or my family incur with Richard Waller, Jr., D.C.. If I have financial difficulties/hardships, I shall pay Richard Waller, Jr., D.C. according to the terms of any agreement that I make with Richard Waller, Jr., D.C.. This authorization serves as a Doctor's Lien, directing my attorney to withhold from any settlement, judgment, or verdict which may be paid to my attorney or me whatever sum is needed to protect Richard Waller, Jr., D.C., and to pay Richard Waller, Jr., D.C. directly from those proceeds. If Richard Waller, Jr., D.C. has to resort to collection proceedings against me, I agree to pay all collection costs including the fees of collection agents, attorneys, and court costs, in addition to paying all fees due Richard Waller, Jr., D.C. for services rendered by Richard Waller, Jr., D.C. to &/or for me or my family. I authorize Richard Waller, Jr., D.C. and staff to call me on the telephone to discuss appointments, treatment information, and/or any other details related to my/my family's therapy and treatment. Richard Waller, Jr., D.C. and staff may leave messages about appointments on my answering machine. If I am unavailable or incapacitated, I authorize Richard Waller, Jr., D.C. and/or staff to discuss my case with my spouse, parents, adult children, and/or other health care providers. Richard Waller, Jr., D.C. is authorized to release any and all information requested to any other health care provider involved in my care and treatment.

TODAY'S DATE _____ YOUR SIGNATURE _____ CN _____

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