Work Injury Insurance information

Montrose Family Chiropractic
145 Nelson Blvd suite 1000
Po box 406, Montrose, MN 55363
763-330-2302

Patient name: _____ **Date of birth:** _____
Last First Middle initial month/day/year

Address: _____
Street Address po box city state zip code

Phone: Home: _____ Cell: _____

Social Security Number: _____ **Email:** _____

Sex: Male Female **Marital Status:** Single Married other Spouse Name: _____

Employers name: _____ **Work Phone Number:** _____

Emergency contact: _____ **Phone Number:** _____

Do you have health insurance? **Yes** (fill out next section) **No** (skip next section)

_____ _____ _____ _____ _____
Work Comp Insurance Name, **Address of Insurance,** **City** **State** **Zip Code**

Claim adjusters phone number: _____ **Ext:** _____

Claim Adjusters FAX Number: _____ **Claim Adjusters Name:** _____

Policy/ID Number: _____ **Group Number:** _____

_____ _____ _____ _____ _____
Employers Name **Address of Employer,** **City** **State** **Zip Code**

Ave you the primary name on this Insurance Policy? **Yes** **No**

If no, then who is? _____ _____ _____ _____ _____
Last name First Name SSN Date of birth Relationship to insured

Policy/ID Number: _____ **Group Number:** _____

I authorize the release of any medical or other information to Montrose Family Chiropractic as necessary to process this claim. I also request payment of medical benefits from either a government or non-government source to Montrose Family Chiropractic. I authorize Montrose Family Chiropractic to initiate a complaint to the Insurance Commissioner on my behalf. I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered, and I understand that I will be charged 1.5% monthly or (18% annual percentage rate) with a minimum monthly fee of $1.00, on any non-contract insurance balances over 30 days. I further understand that I will be legally responsible for all collection costs involved with the collection of this account including all court costs, reasonable attorney fees and all other expenses incurred with collection if I default on this agreement. In addition, if I issue a check that is returned by the bank for non-sufficient funds, I understand I will be charged for $40.00 for each returned check. While Montrose Family Chiropractic will aide in the processing of my non-contract insurance claim, I understand that if my insurance does not pay within 60 days, my account will be determined as self-pay and due in full by myself. I certify this information is true and correct to the best of my knowledge.

Signature: _____ **Date:** _____

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Work Injury Information

Patient's Name: _____ _____ **Today's Date:** _____
Last, First

Date of Injury: _____

Please describe how the injury happened in detail: _____

_____

_____

Have you reported your injury to your employer: ☐ yes ☐ no

If no. Explain: _____

Was there a witness? ☐ No ☐ Yes, who: _____

Did the company file a First Report of Injury: ☐ No ☐ Yes

When did you report your injury: _____ To whom: _____

Did you work the rest of your shift: ☐ yes ☐ no If yes, how many hours? _____

Did you receive temporary total disability (TTD): ☐yes ☐ no If yes, from who? Dr. _____

Did you receive temporary partial disability (TPD): ☐ yes ☐ no If yes, from who? Dr. _____

Are you working now: ☐ yes ☐ no

When did you return to work? _____ How many work days did you lose? _____

How many hours did you work when you returned to work: _____

Are there limitations as a result of the injury? ☐ yes ☐ no
If yes. Explain changes and limitations: _____

_____

Are you still working at the same job? ☐ yes ☐ no
If you are still working at same employer, has your job description changed? ☐ yes ☐ no

If your employment has changed, present job involves:
☐ office work only ☐ some light lifting
☐ repetitive lifting of____Ibs ☐ maximum lifting up to_____Ibs.
☐ repetitive squatting ☐ repetitive bending ☐ repetitive stooping
☐ repetitive kneeling ___hours per day/___ days per week
☐ other: _____

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Work Injury Information

How long have you been employed with former company:_____

How long have you been employed with present company:_____

Please list former employers - list company names:

1. _____ Injuries ☐ yes ☐ no
2. _____ Injuries ☐ yes ☐ no
3. _____ Injuries ☐ yes ☐ no
4. _____ Injuries ☐ yes ☐ no

As a result of this accident, did you go to the hospital: ☐ yes ☐ no

If yes, please name the hospital: _____City_____

If yes: ☐ immediately ☐ next day ☐ later in same day ☐ other_____

Did you go to the hospital by: ☐ ambulance ☐ private transportation

If yes, how long was your stay? _____

Hospital diagnosis: _____

What recommendations were made: ☐ see your own doctor ☐ see orthopedist/neurologist
☐ physical therapist ☐ braces/collars ☐ prescription ☐ released
☐ see your chiropractor ☐ other_____

Family medical Doctor: _____ Clinic: _____
When doctors work together it benefits you. May we have your permission to update your medical doctor regarding your care at this office? _____

Please list all doctors you have seen as related to the accident:

Name	Address	City	Released
1.			
2.			
3.			
4.			

Please list any special tests ordered by the hospital or doctor:_____

_____

What injuries did you sustain? _____

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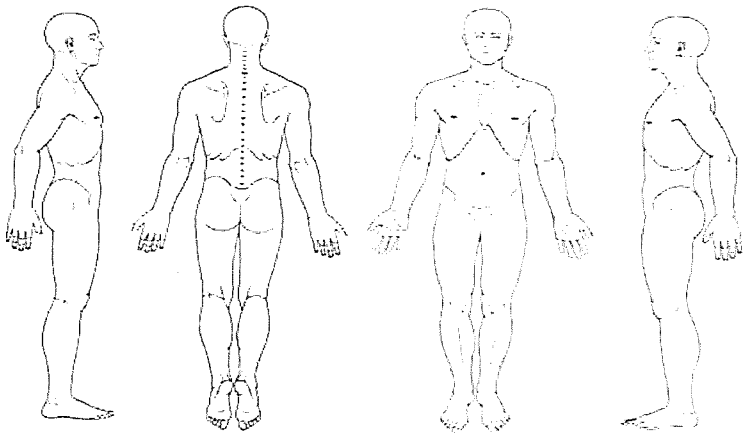
Work Injury Information

How often do you experience your symptoms?

- ☐ Constantly (76-100% of the day)
- ☐ Frequently (51-75% of the day)
- ☐ Occasional (26-50% of the day)
- ☐ Intermittently (0-25% of the day)

What describes the nature of your symptoms?

- ☐ Sharp
- ☐ Dull
- ☐ Numb
- ☐ Shooting
- ☐ Burning
- ☐ Tingling
- ☐ Stabbing
- ☐ Achy



Please indicate where you have pain or other symptoms on the drawing

Did you experience immediate symptoms: ☐ yes ☐ no

If no, when did they first appear?_____

What were your first symptoms?_____

Since the accident do you feel: ☐ worse ☐ no improvement ☐ better ☐ other: _____

Pain Scale On a scale of one to ten, please circle how you would rate your pain. (10 being the worst)

1 2 3 4 5 6 7 8 9 10

ADDITIONAL NOTES:

_____

_____

_____

The Parent Care Solution is a service of Montrose Family Chiropractic. This business helps baby boomers and their parents prepare in advance for the health, financial, legal and emotional issues that accompany aging, unexpected illness or death.
Would you like more information about the Parent Care Solution? ☐ Yes ☐ No
Do you know someone who would like to hear about the Parent Care Solution? ☐ Yes ☐ No

Patient Signature_____ Date_____
(or legal guardian)