## CHIROPRACTIC ASSOCIATES 4444 MAIN STREET BRIDGEPORT, CT 06606

NAME			HOME PHONE	
	First Lo	ist	_ HOME FRONE	
ADDRESS		APT #	CITY	STATEZIP
				#OF CHILDREN
				WORK#
				ZIP
HOW DID YO	U HEAR ABOUT OUR OFFI	CE?		
DOCTOR PRI	EFERRED TODAY?			
YOUR FAMIL'	y physician			
	RY DUE TO AN ACCIDENT			
DESCRIPTION	OF ACCIDENT/INCIDENT	•		
DO YOU HAV	'E HEALTH INSURANCE? <b>Y</b>	ES/NO NAME OF	THE INSURANCE	
	'ER SUFFERED FROM:			
1) DIZZINESS	7) ARTH	IRITIS 13	SINIIS TROUBLE	
	0) HEAL	JACHES 14	) ANEMIA	
	JUDLE 9) ASIH	MA 15	RHEUMATIC FEVER	
J) TUBERCUL	.USIS 11) NER'	RITIS 16	FAMILY HISTORY OF	CANCED
6) ALLERGIES		GNANCY 18	STROKE	CANCER
LIST ANY SURC				***************************************
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AN INSURANCE C	ND AGREE THAT HEALTH A	ND ACCIDENT IN	SURANCE POLICIES A	.RE AN ARRANGEMENT BETWEEN
			AF INI MAMPINIO COLLE	re an arrangement between R Chiropractic associates wil Ction from the insurance
	WIOUNI AID DIRECTLY	( ) ( AKPENIER (		1 A TEC 14/11 - DE DE DE DE
	NECELLI, I CLEARLI UNI	FRIANI) ANI) A	THE THAT ALL CEDITION	CC DELID EDER
	THE THINK IN COUNTY AT	I FEVEL MUNICIPAL	-/ \U U \ \ \ \ \ \ \ \ \ \ \ \ \   \	
EES AND REASON	ABLE ATTORNEY'S FEES.	IAMPLE COSIS OF	COLLECTION, INCLUE	DING COURT COSTS, COLLECTION
PATIENT'S SI	GNATURE:			DATE
				DATE
I ARENI/GU	ardian's signature			DATE

## NAME HOME PHONE First Last ADDRESS\_\_\_\_\_ \_\_\_\_\_APT # \_\_\_\_\_CITY\_\_\_\_\_STATE\_\_\_ZIP\_\_\_\_ S.S.#\_\_\_\_\_E-MAIL\_\_\_\_ BIRTHDATE\_\_\_\_\_AGE\_\_\_\_MALE/FEMALE MARITAL STATUS:\_\_\_\_\_#OF CHILDREN EMPLOYED BY\_\_\_\_\_OCCUPATION\_\_\_\_\_WORK#\_\_\_ EMPLOYER'S ADDRESS \_\_\_\_\_\_CITY \_\_\_\_ZIP\_\_\_\_ SPOUSE'S NAME \_\_\_\_\_SPOUSE'S EMPLOYER SPOUSE'S S.S.#\_ DOCTOR PREFERRED TODAY? YOUR FAMILY PHYSICIAN OTHER DOCTORS SEEN FOR THIS CONDITION IS YOUR INJURY DUE TO AN ACCIDENT/INCIDENT? YES / NO DESCRIPTION OF ACCIDENT/INCIDENT: DO YOU HAVE HEALTH INSURANCE? YES/NO NAME OF THE INSURANCE\_\_\_\_\_ POLICY #\_\_\_\_\_ NAME OF ANY OTHER HEALTH INSURANCE\_\_\_\_ HAVE YOU EVER SUFFERED FROM: 1) DIZZINESS 7) ARTHRITIS\_\_\_\_\_ 13) SINUS TROUBL 8) HEADACHES\_\_\_\_ 14) ANEMIA\_\_\_\_ \_ 13) SINUS TROUBLE 2) BACKACHES 3) HEART TROUBLE\_\_\_\_\_ 9) ASTHMA\_\_\_\_ 15) RHEUMATIC FEVER 10) NEURITIS\_\_\_\_ 16) CANCER 4) DIABETES\_\_\_\_ 11) NERVOUSNESS 17) FAMILY HISTORY OF CANCER 5) TUBERCULOSIS 12) PREGNANCY \_\_\_\_ 18) STROKE \_\_\_\_ 6) ALLERGIES LIST ANY SURGICAL OPERATIONS AND YEARS: I UNDERSTAND AND AGREE THAT HEALTH AND ACCIDENT INSURANCE POLICIES ARE AN ARRANGEMENT BETWEEN AN INSURANCE CARRIER AND MYSELF. FURTHERMORE, I UNDERSTAND CHIROPRACTIC ASSOCIATES OF BRIDGEPORT WILL PREPARE ANY NECESSARY REPORTS AND FORMS TO ASSIST ME IN MAKING COLLECTION FROM THE INSURANCE COMPANY. ANY AMOUNT PAID DIRECTLY TO CHIROPRACTIC ASSOCIATES OF BRIDGEPORT WILL BE CREDITED TO MY ACCOUNT UPON RECEIPT. I CLEARLY UNDERSTAND AND AGREE THAT ALL SERVICES RENDERED ME ARE CHARGED DIRECTLY TO ME AND THAT I AM PERSONALLY RESPONSIBLE FOR PAYMENT. IN THE EVENT OF DEFAULT, THE UNDERSIGNED AGREES TO PAY ALL REASONABLE COSTS OF COLLECTION, INCLUDING COURT COSTS, COLLECTION FEES AND REASONABLE ATTORNEY'S FEES. PATIENT'S SIGNATURE: DATE DATE PARENT/GUARDIAN'S SIGNATURE

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