CHIROPRACTIC ASSOCIATES 4444 MAIN STREET BRIDGEPORT, CT 06606

NAME_________________________________ HOME PHONE_____________________________
First Last

ADDRESS_________________________APT # _______CITY______________STATE_____ZIP__________

S.S.#____________________CELL#_________________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.#________________________

HOW DID YOU HEAR ABOUT OUR OFFICE? ____

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_____
2) BACKACHES_____
3) HEART TROUBLE_____
4) DIABETES_____
5) TUBERCULOSIS_____
6) ALLERGIES____
7) ARTHRITIS_____
8) HEADACHES_____
9) ASTHMA_____
10) NEURITIS_____
11) NERVOUSNESS____
12) PREGNANCY____
13) SINUS TROUBLE____
14) ANEMIA_____
15) RHEUMATIC FEVER____
16) CANCER_____
17) FAMILY HISTORY OF CANCER_____
18) STROKE _____

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 CARPENTER CHIROPRACTIC ASSOCIATES WILL PREPARE ANY NECESSARY REPORTS AND FORMS TO ASSIST ME IN MAKING COLLECTION FROM THE INSURANCE COMPANY. ANY AMOUNT PAID DIRECTLY TO CARPENTER CHIROPRACTIC ASSOCIATES 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 ______________

PARENT/GUARDIAN'S SIGNATURE______________________________DATE ______________

CHIROPRACTIC ASSOCIATES OF BRIDGEPORT 4444 MAIN STREET BRIDGEPORT, CT 06606

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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_____
2) BACKACHES_____
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17) FAMILY HISTORY OF CANCER_____
18) STROKE _____

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 ______________

PARENT/GUARDIAN'S SIGNATURE____________________________DATE ______________

IF YOUR ACCIDENT IS WORK RELATED, PLEASE FILL OUT THE FOLLOWING:

ACCIDENT DATE________ TOWN WHERE ACCIDENT OCCURRED______________________________

DESCRIBE HOW THE ACCIDENT OCCURRED:____

____

DID YOU REPORT YOUR ACCIDENT TO YOUR EMPLOYER? **YES / NO** DID YOU GO TO THE HOSPITAL? **YES/ NO**

WHAT ARE YOUR INJURIES?____

HAVE YOU LOST DAYS FROM WORK? **YES / NO** WHAT DAYS?_____________________________

IF YOUR ACCIDENT IS AUTO RELATED, PLEASE FILL OUT THE FOLLOWING:
PLEASE PROVIDE US WITH THE POLICE REPORT.

ACCIDENT DATE:__________HOUR_____**AM/PM** LOCATION_____________________________

DESCRIBE HOW THE ACCIDENT OCCURRED:____

____

PLEASE CIRCLE ONE: WERE YOU: DRIVER PASSENGER PEDESTRIAN

PLEASE CIRCLE ONE: WERE YOU HIT FROM: FRONT BEHIND SIDE

AS A RESULT OF THE ACCIDENT WAS A TRAFFIC CITATION ISSUED TO YOU? **YES / NO**
TO THE OTHER DRIVER? **YES / NO**

DO YOU HAVE AUTO INSURANCE? **YES / NO** INSURANCE CO:__________________________

POLICY #____________________ AGENT'S NAME AND PHONE #: _________________________

IS THE POLICY UNDER YOUR NAME? **YES / NO** IF NOT, WHO?___________________________

IS THE ACCIDENT REPORTED TO YOUR INSURANCE? **YES / NO**

ATTORNEY'S NAME AND ADDRESS: ____

LIST THE EXTENT OF YOUR INJURIES:____

*****PLEASE CHECK OFF ANY SYMPTOMS YOU HAVE NOTICED SINCE THE ACCIDENT*****

HEADACHES___	DIZZINESS___	LIGHT BOTHERS EYES___	DIARRHEA___
NECK PAIN, STIFF___	HEAD SEEMS HEAVY___	LOSS OF MEMORY___	COLD FEET___
SLEEPING PROBLEMS___	PINS & NEEDLES-ARMS___	EARS RING___	COLD HANDS___
BACK PAIN___	PINS & NEEDLES-LEGS___	BUZZING IN EARS___	UPSET STOMACH___
NERVOUSNESS___	NUMBNESS IN FINGERS___	LOSS OF BALANCE___	CONSTIPATION___
TENSION___	NUMBNESS IN TOES___	FAINTING___	COLD SWEATS___
IRRITABILITY___	FATIGUE___	LOSS OF SMELL___	OTHER__________
CHEST PAIN___	DEPRESSION___	LOSS OF TASTE___	OTHER__________