SILVER CITY CHIROPRACTIC
NEW PATIENT INFORMATION

Date___/___/___

Name_____ Phone(____)_____

DOB____/____/____ S.S#____-____-_____ Cell#(____)_____-_____

Address_____City/ST_____

Zip Code_____

Employer_____ Work # (_____)____-_____

Address_____City/ST_____

Name of Spouse/Parent_____Phone(___)____-___

Address_____City/ST_____

PERSONAL INSURANCE
Name of Insurance Co._____Co-Pay$_____

Please Circle
Date of Accident____/____/_____ Auto/ Workers Comp/ Slip&Fall
Name of Automobile Owner_____Phone#_____
Address_____City/ST_____ZIP_____
Name of Insurance Co_____Phone#_____
Policy#_____ Claim#_____ Adjustor_____

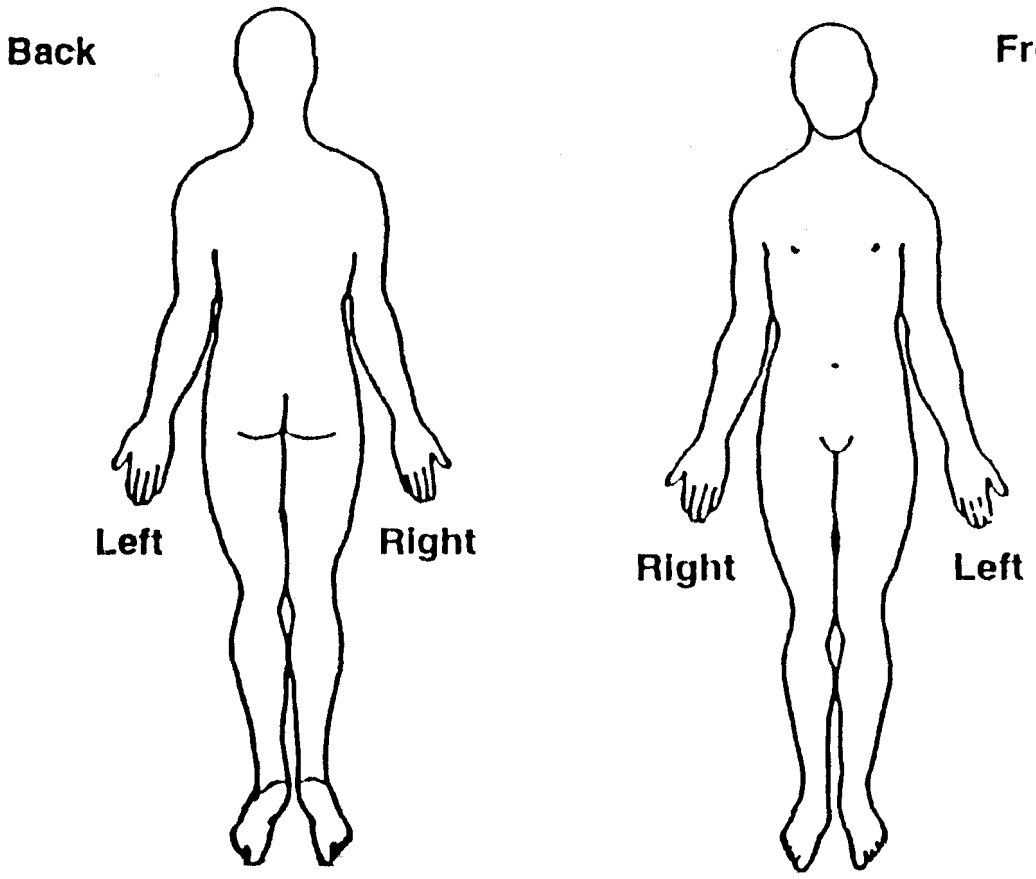
Is an Attorney representing you in this case? Yes or No
Name_____Phone#_____

SILVER CITY CHIROPRACTIC

PAIN DRAWING

Date _____ Name _____

Draw location of your pain on body outlines and mark how bad it is on pain line at bottom of page.



The pain is...

☐ Constant

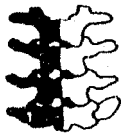
☐ Intermittent; it usually lasts for _____ ☐minute(s) ☐hour(s) ☐day(s) ☐week(s)

Please choose the number which best describes your pain RIGHT NOW:

	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
No Pain	1	2	3	4	5	6	7	8	9	10	Unbearable Pain

The pain is aggravated by: _____

The pain is relieved by: _____



SILVER CITY CHIROPRACTIC

Dr. Michael D. Mederios

Date:___/___/___

I_____give consent for release of my medical records

DOB:____/___/___

___ X-Ray report(s) from_____

___Office Notes from_____

___MRI/EEG report(s) from_____

___Other_____

Patient Signature:_____

Witness Signature:_____

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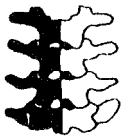

SILVER CITY
CHIROPRACTIC

ASSIGNMENT, LIEN AND AUTHORIZATION
INSURANCE BENEFITS AND ATTORNEY

I hereby authorize and direct you, my insurance company and/or my attorney, to pay directly to Silver City Chiropractic, Inc. such sums as may be due and owing this office for services me both by reason of accident or illness, and by reason of any other bills that are due this office, and to withhold such sums from any disability benefits, medical payments benefits, no fault benefits, workmen's compensation benefits, or any other insurance benefits obligated to reimburse me or from any settlement, judgement or verdict on my behalf as may be necessary to adequately protect said office. This is to act as an assignment of my rights and benefits to the extent of the office's services provided.

In the event my insurance company, obligated to make payments to me upon the charges made by this office for their services, refuses to make such payments, upon demand by me or this office, I hereby assign and transfer to this office any and all causes of action that I might have or that might exist in my favor against such company And authorize this office to prosecute said cause of action either in my name or in the office's name and I further authorize this office to comprise, settle or otherwise resolve said claim or cause of action as they see fit.

I understand that I remain personally responsible for the total amounts due this office for their services. I further understand and agree that this assignment, lien and authorization does not constitute an consideration for the office to await payments and they may demand payments from me immediately upon services at their option.

I authorize the office to release any information pertinent to my case to any insurance company, adjuster or attorney to facilitate collection under this assignment, lien and authorization. I agree that the above mentioned office be given power of attorney to endorse /sign my name on any and all checks for payment of my doctor bill.

Date:_____ Patient Signature:_____

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Injury Due to a Motor Vehicle Accident

Date of accident: _____ Hour:_____ ☐ AM ☐ PM

Were you the ☐ driver ☐ passenger: ☐ front seat ☐ back seat; ☐ pedestrian

Were the roads ☐ dry ☐ wet ☐ snowy/icy

Were you wearing a seat belt? ☐ Yes ☐ No

Were you struck from ☐ behind ☐ driver's side ☐ passenger's side ☐ head on
☐ both front and rear ☐ both front and side ☐ both side and rear

At the time of the impact was your vehicle ☐ stopped ☐ moving forward

Was your air bag deployed? ☐ Yes ☐ No

Do you recall any part of your head or body striking any part of the interior of the car?
☐ Yes ☐ No

If yes, please describe:_____

_____

Type of vehicle you were in:_____

Type of vehicle that struck you:_____

Head/body position at time impact
☐ head turned to left / right ☐ head looking back ☐ head straight forward
☐ body straight in sitting position ☐ body rotated to left / right
☐ other:_____

Were you knocked unconsious? ☐ Yes ☐ No
If yes, for about how long_____ ☐ second(s) ☐ minute(s)

Did you receive first aid at the scene of the accident? ☐ Yes ☐ No

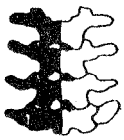
Did you go to the hospital by ☐ ambulance ☐ a friend ☐ drove yourself

Name of hospital:_____

Did the hospital take x-rays? ☐ Yes ☐ No

What treatment was given_____

_____



SILVER CITY
CHIROPRACTIC

Dr. Michael D. Medeiros

CONSENT TO TREAT MINOR

Date:_____

I,_____, give my consent for my

son/daughter, _____, to be treated at

Silver City Chiropractic.

Parent/Legal Guardian Signature:_____

Witness Signature:_____

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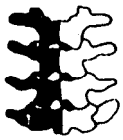

SILVER CITY
CHIROPRACTIC

Dr. Michael M. Medeiros D.C.

Date:_____

This is to confirm that I,_____, have MassHealth/Medicare/Medex for health insurance coverage. I understand that there is no coordination of benefits with auto insurance carriers.

Patients Signature:_____

Witness Signature:_____

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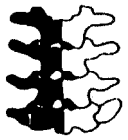

SILVER CITY
CHIROPRACTIC

Dr. Michael D. Medeiros

AFFIDAVIT OF HEALTH BENEFITS

I, _____, do swear that I do not have a health insurance policy in effect under my name or under a member of my household; nor am I a member under any group health insurance policy.

Patient Signature:_____

Witness Signature:_____

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