

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# _____

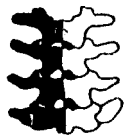
Address _____ City/ST _____ ZIP _____

Name of Insurance Co _____ Phone# _____

Policy# _____ Claim# _____ Adjustor _____

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

Name _____ Phone# _____



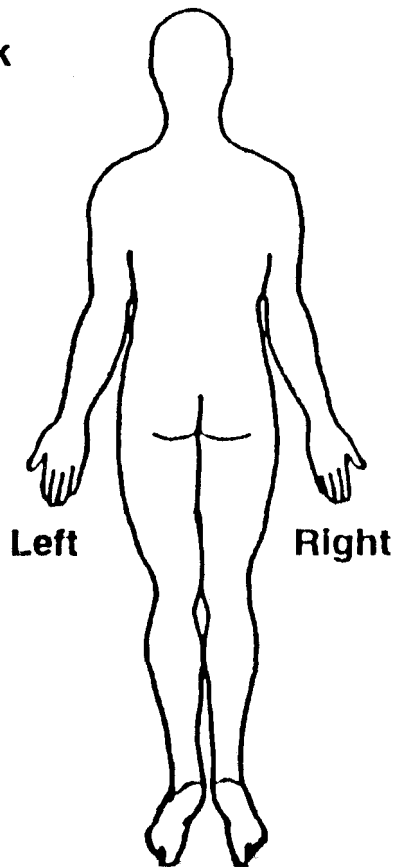
SILVER CITY CHIROPRACTIC

PAIN DRAWING

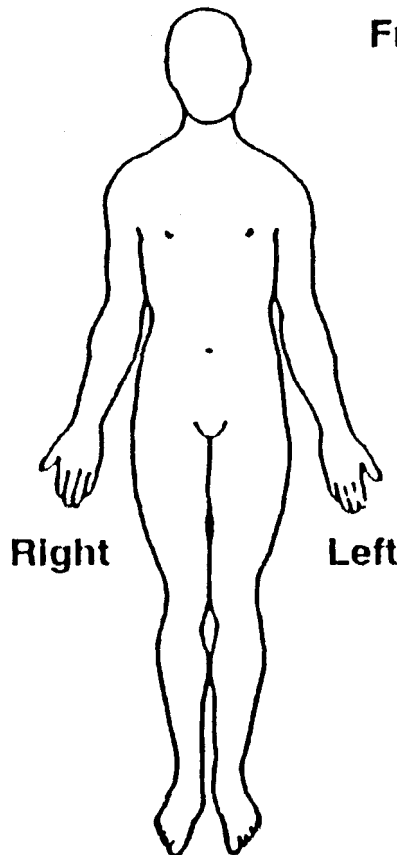
Date _____ Name _____

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

Back



Front



The pain is...

Constant

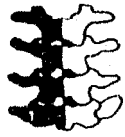
Intermittent; it usually lasts for _____ minute(s) hour(s) day(s) week(s)

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 _____

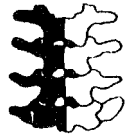
___ Office Notes from _____

___ MRI/EEG report(s) from _____

___ Other _____

Patient Signature: _____

Witness Signature: _____



SILVER CITY CHIROPRACTIC

ASSIGNMENT, LIEN AND AUTHORIZATION INSURANCE BENEFITS AND ATTORNEY

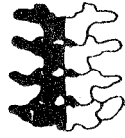
I hereby authorize and direct you, my insurance company and/or my attorney, to pay directly to Silver City Chiropractic, Inc. such sums as may be due and owing this office for services me both by reason of accident or illness, and by reason of any other bills that are due this office, and to withhold 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: _____



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: _____