SLIP & Fall/LIEN CASE HISTORY

Name: ______________________ SS #: ______________

Address: ____
Street City State Zip Code

Home/Cell #: ( )__________( )__________ Work Phone: ______________

Name – Cell Phone Carrier: ______________________ E-mail: ______________

Date of Birth: ______________ Gender: M F Marital Status: M S D W

Employer: ______________________

Insurance Info: ______________________ Policy #: ______________

Policy Holder: ______________________ Group #: ______________

Attorney: ____

Address: ____

Phone #: ______________ ext. ______ Fax#: ______________

Emergency Contact: ______________________ Phone #: ( )__________

Are you working now? ☐ Yes ☐ No Last Date Work: ______________

Date of Injury: ______________ Has a Report been Filed: [ ] Yes [ ] No

Describe How the Injury Occurred: ____

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Where did the injury occurred: ____

Where are you feeling pain? ______________________

Please indicate on the diagram using X where you feeling pain

Is your pain getting: ☐ Better ☐ Worse ☐ Staying Same

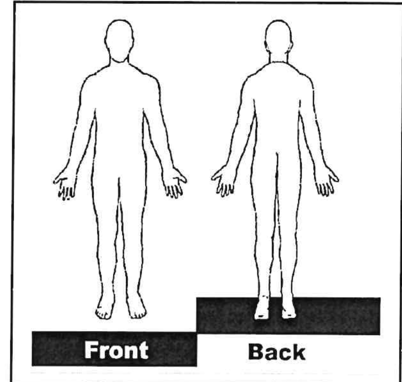
What relieves the pain? ______________________

Does the pain interfere with: ☐ Work ☐ Sleep ☐ Walk ☐ Sit

Have you been treated for present condition? ☐ Yes ☐ No

If yes, who treated you? ______________________

Have you ever had a similar condition, if yes when? ______________________



I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this Chiropractic office will prepare all necessary reports and forms to assist me in making collection from the Insurance Company and that an amount authorized to be paid directly to this office will be credited to my account. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I terminate my care, any fees for services rendered will be immediately due and payable.

Patient's Signature: ______________________ Date: ______________

Guardian's Signature: ______________________ Date: ______________

I hereby authorize the release of my medical records/reports/diagnostic testing results to:
Hillside Chiropractic, PC, 250-20 Hillside Avenue, Bellerose, New York 11426-2149**Tel:718-343-0474*Fax:718-962-2818

Patient's Signature: ______________________ Date: ______________

Guardian's Signature: ______________________ Date: ______________

X-Ray Authorization

[ ] I agree to have X-rays taken [ ] I refuse X-ray testing [ ] I am pregnant [ ] I am not pregnant

Patient's Signature: ______________________ Date: ______________

Guardian's Signature: ______________________ Date: ______________