WORKER'S COMPENSATION CASE HISTORY

Name: _____ SS #: _____

Address: _____
Street City State Zip Code

Home #: ( )_____ Cell #: ( )_____

Name of Cell Phone Carrier: _____ E-mail Address: _____

Work Phone: _____ Work Fax: _____ Supervisor: _____

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

Employer's Name: _____

Employer's Address: _____

Emergency Contact Name/Relationship: _____ Phone #:( )_____

Job Related: ☐ Yes ☐ No Job Title: _____

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

Date of Injury: _____ Was a Report Filed: ☐ Yes ☐ No

Job/Duties/Description: _____

Address where Injury occurred: _____

Workers Compensation Carrier/Address: _____

_____

Carrier Case #: _____ WCB#: _____ WCB#: _____

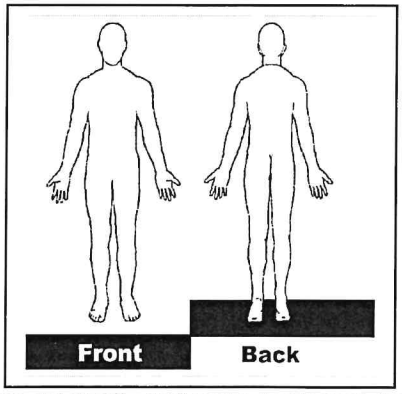
Attorney Info: _____

Describe How This Incident 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, NY 11426**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: _____