CONFIDENTIAL PATIENT HISTORY

LAST NAME_____ FIRST NAME_____ M.I._____

ADDRESS_____

CITY_____STATE_____ZIP_____

HOME PHONE_____ CELL PHONE_____

EMAIL_____

SEX M F DATE OF BIRTH____/____/_____ SOC.SEC._____

MARITAL STATUS S M D W

EMPLOYER INFORMATION

OCCUPATION_____ EMPLOYER_____

EMPLOYER ADDRESS_____CITY_____

STATE_____ WORK PHONE_____

INJURY INFORMATION

TYPE OF INJURY AUTO WORK SLIP AND FALL OTHER_____

DATE OF INJURY_____POLICY #_____CLAIM #_____

DESCRIBE HOW INJURY HAPPENED:_____

DID YOU REPORT THE INJURY?_____ IF SO TO WHOM?_____

WERE YOU HOSPITILIZED?_____ IF SO WHERE_____

X-RAYS TAKEN?_____

WERE YOU WORKING AT THE TIME OF THE ACCIDENT?_____

DATES LOST FROM WORK:_____

NAME OF OTHER DOCTORS SEEN FOR THIS INJURY:_____

NAME OF ATTORNEY_____

PATIENT CONDITION

MAIN COMPLAINT_____

WHEN DID SYMPTOMS START_____

IS THIS CONDITION WORSENING_____

RATE THE SEVERITY OF PAIN 1(least pain) to 10(severe pain) _____

PATIENT HISTORY

WHAT TREATMENT HAVE YOU RECEIVED?_____

WHAT MEDICAL CONDITIONS DO YOU HAVE?_____

WHAT MEDICINES ARE YOU TAKING?_____

WHAT SURGERIES HAVE YOU HAD?_____

METHOD OF PAYMENT

PRIMARY HEALTH INSURANCE

INSURANCE COMPANY NAME_____

INSURANCE COMPANY PHONE#_____

ID#_____GROUP#_____

POLICY HOLDER'S NAME_____

POLICY HOLDER'S DATE OF BIRTH_____

RELATIONSHIP TO INSURED SELF SPOUSE CHILD OTHER_____

SECONDARY HEALTH INSURANCE_____

INSURANCE CO. PHONE#_____

ID#_____ GROUP#_____

NO FAULT/WORKER'S COMPENSATION INSURANCE:

INSURANCE COMPANY NAME_____

ADDRESS_____PHONE NUMBER_____

CLAIM #_____ POLICY#_____

DATE OF ACCIDENT_____

ASSIGNMENT OF BENEFITS RIGHT FOR DIRECT PAYMENT TO DOCTOR

PRIVATE &GROUP HEALTH INSURANCE ASSIGNMENT FOR DIRECT PAYMENT TO DOCTOR

I hereby instruct and direct the _____Insurance company to pay by check made out and mailed directly to: Richard Grosso, D.C P.C.

For professional or medical expenses benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered.

THIS IS A DIRECT ASSIGNMENT of MY RIGHTS and BENEFITS UNDER THIS POLICY

This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay my balance of said professional service or charges over and above the insurance payment.
I also understand and agree that I am ultimately responsible for all fees including reasonable collection costs. This assignment of benefits does not release me from my obligation to pay professional fees.

A PHOTOCOPY OF THIS ASSIGNMENT SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL.
I authorize the release of any information pertinent to my case to any insurance company, adjustor or attorney involved in this case.

_____ _____

Name of Patient (please print) Date

_____ _____

Signature of Patient (or guardian if minor) Date