Is your condition related to an accident (either personal, work, or auto)? Yes/No

If no, please continue to bottom section of page.
If yes, please list DATE of injury and nature of accident: _____
Auto Work Personal Other

If work related accident:

Do you intend to charge your treatments to a Workman's Compensation claim? Yes/No

If yes, please list employer/company name, address, and phone:

_____

_____

_____

Has an initial report of injury been filed with your insurance company through your employer? Yes/No

If auto accident:

Do you intend to charge your treatments to a Personal Injury/Motor Vehicle Accident claim? Yes/No

If yes, please provide the insurance information for the company to be billed:
Company Name: _____
Name of Insured: _____
Claim number (if available): _____
Name and phone number of claims adjustor (if available):_____
_____

If personal accident:

Please describe the nature of the accident:

_____

_____

_____

_____

I hereby certify that the information provided in this application for care is accurate and true to the best of my knowledge. I (We) agree to see that services rendered to the patient are paid in full as incurred. In addition, if for any reason I choose to terminate or suspend my treatment, any outstanding fees for professional services will immediately due and payable.

Patient Signature_____ Date _____
Parent/Guardian signature (if patient under 18) _____ Date_____