Callahan Chiropractic, Inc

James Callahan, D.C. Promoting Spinal Health for Whole Body Wellness

GENERAL INFORMATION FORM

Name: ______________________ Date: ______________________

Address: ______________________

City: ______________________ State: ______________ Zip: __________

Home phone: ______________________ Work phone: ______________________

Referred by: ______________________ Date of birth ________ : ______ Age: ________

Occupation: ______________________ Employer: ______________________

Marital status: S M D W Spouse's name: ______________________

Number of children: ______________________

In case of emergency contact: ______________________

Relationship: ______________________ Phone number: ______________________

Health insurance Company: ______________________

Address: ______________________

Phone number: ______________________ Policy number: ______________________

Name of policy holder: ______________________

Policy holder's address: ______________________

Policy holder's phone number: ______________________ Policy holder's DOB: ______________________

Policy holder's employer: ______________________

Are you here today due to an auto accident? Yes _____ No _____

Date of accident: ______________________

If you missed any work due to the accident, what dates? Claim number: ______________________

Name of policy holder of vehicle you were in: ______________________

Name, address, and phone number of auto insurance company: ______________________

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Name of adjuster, phone number, and extension: ______________________

If you have an Attorney for this case, give name, address, and phone number: ______________________

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Are you here today for a work-related accident? Yes _____ No _____

Date of accident: ____

Dates missed: ____

If Workman's Compensation accident, give name, address, and phone number of employer: ___________

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Claim number: ____

Name, address, and phone number of employer's insurance company: ______________________

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Purpose of this appointment: ____

Have you been under drug and/or medical care? Yes _____ No _____

What medications are you currently taking? ____

____

Have you had any type of surgery? Yes _____ No _____

What type of surgery, and when was the surgery performed? ______________________

____

Other symptoms you have felt:

___ headaches
___ neck pain
___ sleeping problems
___ back pain
___ nervousness
___ tension
___ loss of balance
___ tingling in toes
___ irritability
___ chest pain
___ dizziness
___ neck stiff
___ fatigue
___ depression
___ cold sweats
___ tingling in fingers
___ fever
___ ears ringing
___ buzzing in ears
___ constipation
___ diarrhea
___ fainting
___ numbness in toes/fingers

Cash: Patients are required to pay at the time of each visit. We accept cash, checks, Visa and MasterCard.

General Insurance: Patients are responsible for payment at the time of each visit. Patients are responsible for deductibles, co-payments, non-covered services, and referrals if required.

Blue Cross/Blue Shield of Mass: The doctor in this office is a participating Blue Cross/Blue Shield provider. When verification has been completed, we will accept assignment as specified by Blue Cross/Blue Shield for your particular plan. Patients are responsible for all deductibles, co-payments, and non-covered services.

Medicare: The doctor in this office is a participating Medicare provider. Medicare recipients must present their enrollment cards at the onset of treatment. Medicare requires a $100 annual deductible to be paid before services are covered. In compliance with the Federal MAAC regulations, the fee for a spinal manipulation has been set at $30.00. Spinal Manipulation is the only service covered by Medicare. If the patient does not have a second insurance or the second insurance does not cover the treatment, the patient will be required to pay a co-payment.

Worker's Compensation: Patients must report injury to employer within 3 to 5 days after injury. When the proper forms are filed, we will accept assignment as a work-related case. If the patient's injury is not found to be work-related and is denied by the insurance company and the Industrial Accident Board, the patient will be responsible for payment of his/her bill either through their medical insurance carrier or themselves.

Auto Accident/Personal Injury: Patients are required to complete a Personal Injury Protection Form. When the proper forms are filed and verification has been completed, we will accept assignment for medical costs covered by your insurance. If an attorney is involved, you must return the Lien Form and your P.I.P. Form by your next visit.

Patient's signature: ____ Date: _________________________

I understand and agree that all fees for professional services rendered in my behalf are my personal responsibility and are due and payable at the time services are rendered. I understand that any fees not paid by my insurance company will be paid directly by me upon notification. I hereby authorize and direct Dr. James Callahan, D.C., of Callahan Chiropractic Office, to release all medical information necessary to process this claim.

Patient's signature: ____ Date: _________________________

I hereby authorize and direct my insurance carrier to pay all benefits, which may be due to me according to my policy, directly to Dr. James Callahan, D.C., of Callahan Chiropractic Office, to be applied towards my account.

Patient's signature: ____ Date: _________________________