

**WINCHESTER HOSPITAL CHIROPRACTIC CENTER
PATIENT INFORMATION – MOTOR VEHICLE ACCIDENT**

Name: _____				
First Name	Middle Name	Last Name		
Sex: <u> </u> M <u> </u> F	Date of Birth: _____	SSN _____		
Home Address: _____				
Street	Apt #	City	State	Zip
Home Telephone: _____		Work Telephone: _____		
Marital Status: _____		Employer: _____		

Emergency Contact: _____	
Name	Relationship
Telephone: _____	

MOTOR VEHICLE ACCIDENT INSURANCE INFORMATION	
Date of Accident: _____	
State Where Accident Occurred: _____	
Your MVA Insurance Company: _____	
Claim # _____	Policy# _____
Claims Adjuster: _____	
Claims Adjuster Telephone: _____	
Your Attorney: _____	
Address: _____	
Telephone: _____	

Continue on Reverse Side

YOUR HEALTH INSURANCE INFORMATION

Name of Insurance Company: _____

Policy # _____ Group# _____

Subscriber: _____ Relationship: _____

Subscriber's Date of Birth: _____ Subscriber's Employer _____

Date of Injury: _____ (If applicable)

CONSENT TO TREAT:

I consent to be treated by the Chiropractor(s) and staff of Winchester Hospital Chiropractic Center.

Sign: _____

Date _____

Patient or Personal Representative

ASSIGNMENT OF INSURANCE BENEFITS:

I request payment of insurance and/or Medicare benefits be made on my behalf to (Corporation).

I understand all copayments are due on the date of service.

I understand I am financially responsible for any treatment or balances not paid by my insurance company.

Sign: _____

Date _____

Patient or Personal Representative

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge receipt of Notice of Privacy Practices.

Sign: _____

Date _____

Patient or Personal Representative