WINCHESTER HOSPITAL CHIROPRACTIC CENTER
PATIENT INFORMATION – WORKERS' COMPENSATION

Name:____
First Name **Middle Name** **Last Name**

Sex: __M__F **Date of Birth:**_______________ **SSN**_________________________

Home Address:____
Street **Apt #** **City** **State** **Zip**

Home Telephone:________________________ **Work Telephone:**___________________

Marital Status:__________

Emergency Contact:____
Name **Relationship**
Telephone:_______________________________________

WORKERS' COMPENSATION ACCIDENT INSURANCE INFORMATION

Date of Accident:______________________________

Employer:____

WC Insurance Company:____

Claim #____________________________________

Adjuster:_______________________________________

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