O'Malley Family Chiropractic

Please Print Clearly and fill In completely.

Print Name _____ **Email** _____

Street Address_____ **Phone** _____

City _____ **State** _____ **Zip** _____ **Date of Birth** _____

Age_____ ***Please Check*** ✓ Sex: Male❑ Female❑ Right handed❑ Left handed❑

Auto Accident History: *Please Check* ✓ Driver❑ Passenger❑ Front-seat❑ Seat belted❑

Hit from behind❑ Hit head-on❑ Driver-side impact❑ Passenger-side impact❑; Upon impact, were you thrown Back and forth❑ Side to side❑ Other❑**; Were** you knocked unconscious? Yes❑ No❑
Did you hit or bruise any part of your body? Yes❑ No❑ If Yes, where?_____
Did you notice pain right away? Yes❑ No❑ What symptoms do you currently have that started after the accident?_____
Were you seen at any hospital? Yes❑ No❑ If Yes, when and where?_____
Were you transported by ambulance? Yes❑ No❑ Have you seen your PCP? Yes❑ No❑
Describe how accident happened? _____
_____
_____

Health History:

List any current health conditions:_____

List any current Medications:_____

List any past surgeries & dates: _____

List any past accidents & dates:_____

List any x-rays you've had in the past 2 years:_____

Personal & Work History: *Please Check* ✓ Married❑ Single❑ # of children _____

Your Occupation:_____ Work Duties_____

Work Address:_____Cell Phone:_____

Emergency Contact:_____Emergency contact's phone:_____

Chiropractic History:

Have you ever been to a Chiropractor before? Yes❑ No❑ If yes Doctor's Name _____

Date of last chiropractic visit _____ Reason for care_____

Date of last chiropractic x-rays _____ How long were you under care? _____

Authorization to contact you and/or leave messages:

_____Please initial if we may contact you at home for appointment reminders and about account information.

_____Please initial if we may leave messages regarding your appointments on your answering machine or with your spouse/partner. Name of spouse/partner_____

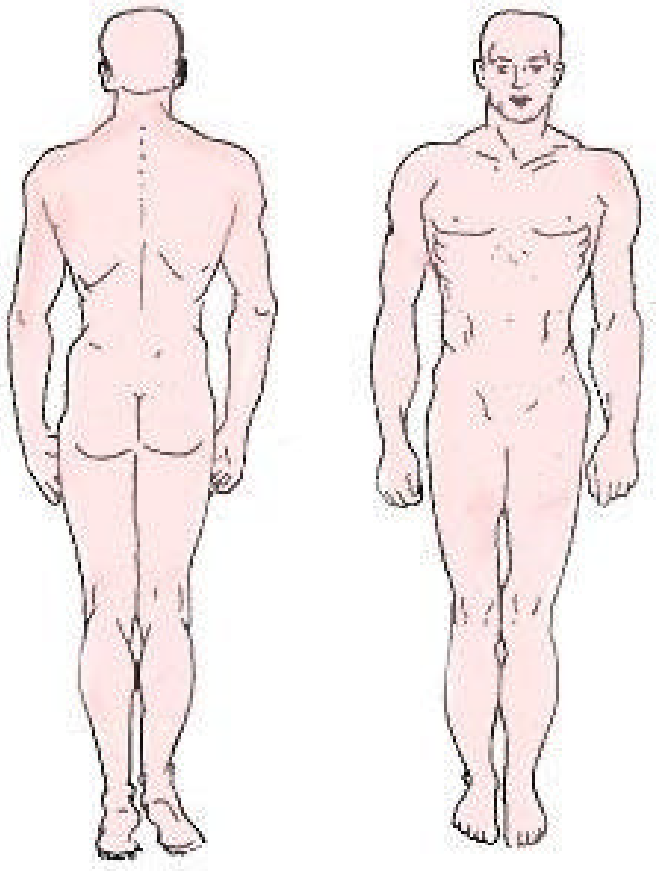
Where did you hear about our office,
or who referred you?_____

FEMALES: ***Please Check One*** ✓ Is there a possibility of you being pregnant? **Yes❑** **No❑**

Please Fill in Below If you have had the following, or if you suffer from the following, *Please Check* ✓

Condition, Symptom Or Problem	Currently	In The Past
Headache	❑	❑
Migraines	❑	❑
Neck Pain	❑	❑
Shoulder Pain	❑	❑
Arm/Hand Pain	❑	❑
Mid Back Pain	❑	❑
Low Back Pain	❑	❑
Hip Pain	❑	❑
Leg/Foot Pain	❑	❑
Disc Problems	❑	❑
Arthritis	❑	❑
Other joint pain	❑	❑
Numbness in hands or arms	❑	❑
Numbness in leg or feet	❑	❑
Dizziness	❑	❑
Allergies	❑	❑
Weakness	❑	❑
Fatigue	❑	❑
Nervousness	❑	❑
Insomnia	❑	❑
Heart Problems	❑	❑
Frequent colds	❑	❑
Nose Bleeds	❑	❑
Ringing in Ears	❑	❑
High or	❑	❑
Low blood pressure	❑	❑
Cough	❑	❑
Chest pain	❑	❑
Menstrual cramps	❑	❑
Weight changes	❑	❑
Asthma	❑	❑
Cancer	❑	❑
Osteoporosis	❑	❑
Diabetes	❑	❑
Cold hands or feet	❑	❑
Digestive problems	❑	❑
Urinary Problems	❑	❑
Skin conditions	❑	❑
Other _____	❑	❑

Circle the areas where you have any problems. Please also describe these problems.



Indicate the severity of your pain:

0 1 2 3 4 5 6 7 8 9 10
Mild Moderate Severe

Please circle the quality of pain:

Aching	**Burning**	**Soreness**
Stiffness	**Numbness**	**Tingling**
Throbbing	**Pins & Needles**	**Stabbing**

Additional information:

_____

_____

Thank you for being complete and thorough.

Your Signature Below Please

_____

Date: _____

O'Malley Family Chiropractic
80 Worcester St. Suite#2 N. Grafton, MA 01536
Phone:(508)839-0040 Fax:(508) 839-0043

NOTICE OF IRREVOCABLE LIEN AND ASSIGNMENT OF BENEFITS AUTHORIZATION FOR RELEASE OF TREATMENT RECORDS

PROVIDER'S LEGAL AND EQUITABLE LIEN-ATTORNEY'S ACCEPTANCE

Name of Practice and Providers: O'Malley Family Chiropractic, Dr. Thomas O'Malley, DC & Dr. Kathleen O'Malley,DC

Patient Name and Address: _____

_____

Name of Insured (PIP):_____Name of Insurer (PIP) _____

Date of Injury/Illness:_____

Name of Insured (BI):_____ Name of Insurer (BI)_____

Name of Law Office & Attorney: _____

In consideration of the agreement of the Provider named above to provide me with injury treatment services, I hereby to the extent of my treatment bills irrevocably assign to my Provider all my right, title and interest to and in all applicable insurance and indemnification reimbursement benefits of applicable insurance companies including but not limited to: Automobile PIP (Personal Injury Protection) Coverage; Medical Payment Coverage and Health Care Coverage to which I may be entitled to pay my Provider for services rendered to me on and after the above date in connection with my injury or illness.

I further grant my Provider an Irrevocable Equitable Lien and Official Legal Lien in the same manner and effect as described in Ch 111?70A through Ch 111? 70D Mass. General Laws to and in any insurance benefits that may be due me and I furthermore authorize my provider to provide my attorney and any insurance companies involved with a full report concerning my condition and treatment, including but limited to office notes, dates of visits and charges incurred.

I hereby authorize and direct any and all applicable insurance companies to make immediate payment directly to my said Provider for all benefits and sums due me that may be due him or her upon receipt by you of my Provider's itemized statement for evaluation and treatment services rendered to me.

It is further agreed upon that payment by any insurance company involved as herein directed to my Provider of any itemized statement shall be considered the same as paid by the insurer directly to me.

I am aware that I remain personally responsible to my Provider for the full amount of my unpaid treatment bills and further direct any Attorney representing me to withhold from the proceeds upon any final settlement or final disposition of my case an amount equal to that to pay any outstanding unpaid balance of my bills. This includes any balance due as a result of an independent medical exam that discontinued my personal injury protection benefits and/or my medical payments benefit.

Patient's Signature:_____ Date: _____

Parent/Guardian's Signature: _____ Date: _____

AGREEMENT OF ATTORNEY:

I hereby agree to honor the above irrevocable Lien and Assignment and pay the Provider all sums received by me from insurers attributable to the Provider's bills and also agree to pay the Provider any lawful balance due from the proceeds of any settlement or recovery.

Attorney's Signature:_____ Date:_____

A photocopy of this form can be accepted with the same authority as the original.

Billing Information:

Patient Name:_____ **Date of Birth:**_____

Name of Insured:_____

Auto Insurance Co.(vehicle you were in): _____

Insurance Co. Address: _____
(Street) (City)
_____ **Phone #**: _____
(State) (Zip)

Fax #:_____ **Claim #**:_____

Adjustor: _____**Ext:** _____

BI (Name of Insured):_____

BI Carrier (Other persons auto ins.) _____

(If Applicable)
Attorney Name: _____

Attorney Address:_____

Phone#: _____ **Fax #:** _____

HEALTH INSURANCE AFFIDAVIT

Your claim for Personal Injury Protection benefits may be coordinated with your own personal Health Insurance per MGL c.90, Section 34M. In order to properly determine what benefits are payable, it is necessary for you to provide us with the information requested below. Thank you very much.

1. Are you eligible for coverage under any Health Insurance Plan? Yes❑ No❑

A. If Yes, please answer or provide a copy of your health card, both sides.

Name of plan:_____

Address for claims:_____

_____Telephone #: _____

Policy #: _____ Group plan #:_____

Subscriber/Member Name:_____

Relationship to you:_____ Date of Birth: _____

Address (if different from yours):_____

B. If No, are you eligible for health coverage under any government program? Yes❑ No❑

Signature:_____ **Date:**_____