Advantage ChiroCare

Dr. Jim Donoghue D.C., I.D.E.

For Official Use Only:
FILE#: ______________________ C_______ PI _______ GI ______ WC ______ OTHER ______
Doctor: ______________________ Coverage / Limitations: ___________________________________
Claim #: _____________________ ____

First Name: _______________________________M.I. ______ Last Name: _________________________________
Address: __________________________________Apartment #: __________City: _____________________________
State: ______________________Zip: ______________ E-Mail Address: _____________________________________
Work Phone #: (   ) _____________ Home Phone #: (   ) _____________ Cell #: (   ) _______________________
Social Security #: ____Sex: ____________________________
Marital Status: S M D Sep. W Birth date: ____
Employer: ____ Address: ______________________________________
City: ________________________________ State: __________________ Zip:________________________________
Occupation: ____________________________________ Primary Doctor: ____________________________________

INSURANCE INFORMATION: (Group:____ Private_____ Work/Comp____ Auto_____) Policy#________________
Name of Insured: ____________________________ Relationship to Patient ________________SS#_______________
Insurance Company: __________________________________ Group#_______________________________________
Address: ____Phone #: (   )_____________________________
Do you or your spouse have any additional insurance? Yes_______ No _______
INSURANCE INFORMATION: (Group:____ Private_____ Work/Comp____ Auto_____) Policy#________________
Name of Insured: ____________________________ Relationship to Patient ______________SS#_________________
Insurance Company: __________________________________ Group#_______________________________________
Address: ____Phone #: (   )______________________________
Do you or your spouse have any additional insurance? Yes_______ No _______

What is your major complaint? ____
Is this condition due to an: A) Auto Accident B) Work Injury C)Other Accident D) Unknown Cause E) Illness
Other Complaints: ____
How long have you had this condition? ____
Have you had this or similar conditions in the past? ____
What activities aggravate your condition?____
Is this condition progressively getting worse? Yes_______ No_______ Constant _______Comes and goes_________
Is this interfering with your: Work_______ Sleep_______ Daily Routine_______ Other _________________________
List surgical operations/ procedures: ____
____
List all medications you are taking: ____
____
List recent tests: (blood, urine, x-rays, MRI, etc.)____
____

OTHER DOCTORS SEEN FOR THIS CONDITION: ____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I authorize payment from my insurance carrier directly to this office with the understanding that all monies will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, fees for professional services rendered me will be immediately payable. In the event of default I promise to pay legal interest on the indebtedness together with such collection costs and reasonable attorney fees as may be required to effect collection.

Patient's Signature____ Date______________________________________