W. C.

MIDDLEBURG HTS CHIROPRACTIC OFFICE

DR. ROY A. GOLSCH, D.C.

PATIENT REGISTRATION

PLEASE PRINT- WRITTEN INFORMATION WILL NOT BE ACCEPTED

TODAY'S DATE ____________ HOME PHONE NUMBER: ( ) ________________

PATIENT'S FULL NAME ________________________________ BIRTHDATE ____/____/____ AGE: ______

PATIENT'S ADDRESS ____

STREET CITY STATE ZIP

SEX MALE( ) FEMALE( ) SOCIAL SECURITY #: ________________ DRIVER LICENSE# ________________

MARTIAL STATUS: ( ) SINGLE ( ) MARRIED ( ) WIDOW ( ) DIVORCED

RACE: ( ) AMERICAN INDIAN/ALASKAN NATIVE ( ) ASIAN ( ) AFRICAN AMERICAN ( ) CAUCASIAN ( ) OTHER ( ) DECLINED

ETHNICITY: ( ) HISPANIC ( ) NON-HISPANIC ( ) DECLINED

EMPLOYER: ______________________________ EMPLOYER PHONE # ( ) ________________

SPOUSE'S NAME: ____________ DATE OF BIRTH: ___/___/_____ SOCIAL SECURITY# ________________

MEDICARE# ________________ MEDICAID# ________________ OTHER ________________

PRIMARY INSURANCE: ______________________________ POLICY HOLDER: ________________

SECONDARY INSURANCE: ______________________________ POLICY HOLDER: ________________

IN CASE OF EMERGENCY PLEASE NOTIFY: ____________________ PHONE: ________________

RELATIONSHIP ________________ ADDRESS: ______________________________

INJURY INFORMATION

DATE OF INJURY: ___/_____/_______ RELATED TO ACCIDENT : NO YES AUTO (PLEASE CIRCLE ONE)

STATE WHERE ACCIDENT OCURRED: ________________

NATURE OF THE ACCIDENT: ( ) INJURED AT HOME ( ) INJURED AT SCHOOL ( ) INJURED DURING ( ) MOTORCYCLE ACCIDENT ( ) RECREATION ( ) WORK INJURY/NON-COLLISION ( ) WORK INJURY/SELF EMPLOYED ( ) WORK INJURY/COLLISION

ATTORNEY NAME: ____________________ ADDRESS: ______________________________

HISTORY OF INJURY: IN YOUR OWN WORDS, PLEASE BRIEFLY DESCRIBE YOUR INJURY: ________________

PREVIOUS CONDITIONS AND TREATMENT: IN YOUR OWN WORDS, PLEASE LIST ANY PREVIOUS MEDICAL CONDITIONS AND TREATMENT: ______________________________

ASSIGNMENT AND RELEASE

I, UNDERSIGNED HAVE INSURANCE COVERAGE WITH THE ABOVE MENTIONED INSURANCE CARRIER(S) AND ASSIGN DIRECTLY TO DR. ROY A. GOLSCH, D.C., ALL MEDICAL BENEFITS, IF ANY- OTHERWISE PAYABLE TO ME FOR SERVICES RENDERED I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY INSURANCE. I HEREBY AUTHORIZE DR. ROY A. GOLSCH, D.C., TO RELEASE ALL INFORMATION NECESSARY TO SECURE THE PAYMENT OF BENEFITS I AUTHORIZE THE USE OF THIS SIGNATURE ON ALL MY INSURANCE SUBMISSIONS **NO INFORMATION PERTAINING TO YOUR CARE WILL BE RELEASED TO ANY OTHER ENTITY WITHOUT YOUR SPECIFIC AUTHORIZTION.

SIGNATURE: ______________________________ DATE: ________________

Worker's Comp Incident Form

Patient Name ______________________________ Today's Date ____________

Name of Compensation Carrier: ________________________________.

Name of Employer: ____.

The date of the work related injury was: ____________________________.

The time that the injury occurred was: ______________________ a.m. / p.m.

The last date worked was: (month)______/ (day)_______/(year)__________.

Were you hospitalized? ☐ Yes ☐ No. If yes, please answer the questions below.

When were you hospitalized? ☐ immediately ☐ later same day ☐ next day ☐ date ___________

How were you transported to the hospital? ☐ ambulance ☐ life flight ☐ private transportation

What did the hospital recommend? ☐ no instructions ☐ see this clinic ☐ see DC
☐ see own doctor ☐ see orthopedist ☐ see neurologist ☐ prescription medication
☐ other: ____

Did you have any xrays taken? ☐ Yes ☐ No
If yes, what areas? ____

My current job status is: (please mark the appropriate response below)

- ☐ off work as a result of the injuries sustained in the reported work accident.
- ☐ working full duty.
- ☐ working light duty.

I ☐ have ☐ have not been involved in previous work related accidents/injuries.

If you have been involved in previous work related accidents/injuries, please complete below.

Status of previous injuries:

- ☐ treated and resolved
- ☐ treated, unresolved, and located at an unrelated area to this accident
- ☐ treated, unresolved, same area as current injury
- ☐ not treated and a completely different area than current injury
- ☐ not treated and still have residual symptoms
- ☐ not treated and do not have any residual symptoms

This accident was: ☐ not reported to the employer. ☐ reported to the employer.

The name of the employee it was reported to was: ____.

Employee's Job Title ________________________________ Phone # _(_______)______-_______.

The injury occurred at (location): ____.

How many hours did you work that same day prior to the accident: __________.

What type of work were you performing at time of injury: _______________________________
____.

Describe the accident: ____
____
____
____.

I have:

- ☐ **been treated by another doctor for the injuries sustained in this accident.**
- ☐ **not been treated by another doctor for the injuries sustained in this accident.**

If you have been treated by another doctor, please continue with the following questions.
List the doctor's name and current/past treatment: _________________________________
____
____.

As a result of the treatment received thus far:

- ☐ **My condition has improved**
- ☐ **My condition has not improved**
- ☐ **My condition has worsened since the injury despite treatment received thus far.**

MIDDLEBURG HTS. CHIROPRACTIC OFFICE, INC.

15350 E. Bagley Rd. • Middleburg Hts., Ohio 44130

DR. ROY A. GOLSCH, *CHIROPRACTIC PHYSICIAN*

Patient Consent Agreement

PATIENT:____

Agrees, that if Worker's Compensation denies payment of claim, that Middleburg Hts. Chiropractic Office, Inc. will submit the billing to the patient's insurance company. We will accept what the insurance company pays as payment in full. If no insurance coverage is available, patient will be responsible for payment.

DATE:_____________________ ______________________________

Patient Signature

____

Witness

Insurance Co.______________________________________

Certificate #:______________________________________

Make a copy of patient's insurance card