Advantage ChiroCare and Wellness Center
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_____