Worker's Compensation Questionnaire

Bromberg Chiropractic Office
201 Broadway Cambridge MA 02139

Dear Patient: This information is considered confidential. We need this information to help determine how chiropractic may help you, as well as filling out the necessary insurance forms. Please take the time to complete this form as accurately as possible. Thank you.

Patient Information

Name _____ Sex _____ Today's Date _____/_____/_____
Address _____ Home Tel (____) _____ Work Tel (____) _____
City, Zip _____ Soc. Sec _____-____-_____ Birth date _____/_____/_____
Occupation_____ Marital Status _____

Employer

Employer Name_____
Employer Address_____
Employer Telephone #_____
Injury reported to_____Contact person_____

Injury Information

1) **Date and time** of accident ___/___/___, _____ Town where accident occurred _____
2) Was accident reported to employer? yes no.
3) Have you lost time from work: yes no. If yes how many days?_____
4) Please explain how the accident happened: _____

_____

_____

_____

5) List the extent of injuries, as you know them: _____
6) Where did you go immediately after the accident? Home _____ Emergency room____ other _____
   a) If you went to an emergency room, please list name and address of hospital
   _____
   b) Were x-rays taken? Yes No What area of body? _____
   c) Was medication prescribed? Yes No Name: _____
   d) What was the Doctor's diagnosis and recommendation? _____
   _____

7) Have you been seen by any other doctors or chiropractors for this condition? Yes No

If so, please fill out below

a) Name and address of doctor(s): _____

b) Dates seen: _____

c) Were x-rays taken? _____ What treatment was provided? _____

a) Name and address of doctor(s): _____

b) Dates seen: _____

c) Were x-rays taken? _____ What treatment was provided? _____

8) Have you had any injuries or complaints similar to those you are now experiencing? Yes No

Describe injury and name of doctors seen for this condition: _____

_____

_____

9) Please describe in detail your physical work activities (see *Jobs Demand Questionnaire*): (i.e. sitting for 2-3 hours in front of a computer screen, lifting heavy objects across the room 10 times per day, etc.)

_____

_____

Insurance Information:

1) Worker's Compensation Carrier_____

2) Carrier address_____

3) Carrier telephone number_____

4) Claim number_____ Name of adjustor_____

5) Have you obtained an attorney? Yes No

If so, please list name and phone number:

_____

Authorization

I hereby assign, transfer, and set over to Dr. Steven J Bromberg all of my rights, title, and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization shall remain valid until written notice is given by me revoking said authorization. I understand that I am financially responsible for all charges whether or not they are covered by insurance.

Patient signature _____ Date _____

Patient Name: _____ Date_____

1) Indicate with a **mark** on this line, the level of pain you are now experiencing:

No Pain |----------| **Maximum Pain**
0 1 2 3 4 5 6 7 8 9 10

2) Listed below are **5 types** of pain. **Select the type** (or types) of pain that you are experiencing.
3) Mark the body figures (**draw below**) to indicate where on you body the pain is being felt.
Be sure to **use** the corresponding **symbols** for each type of pain.
4) Please **draw your face** on the figure below.

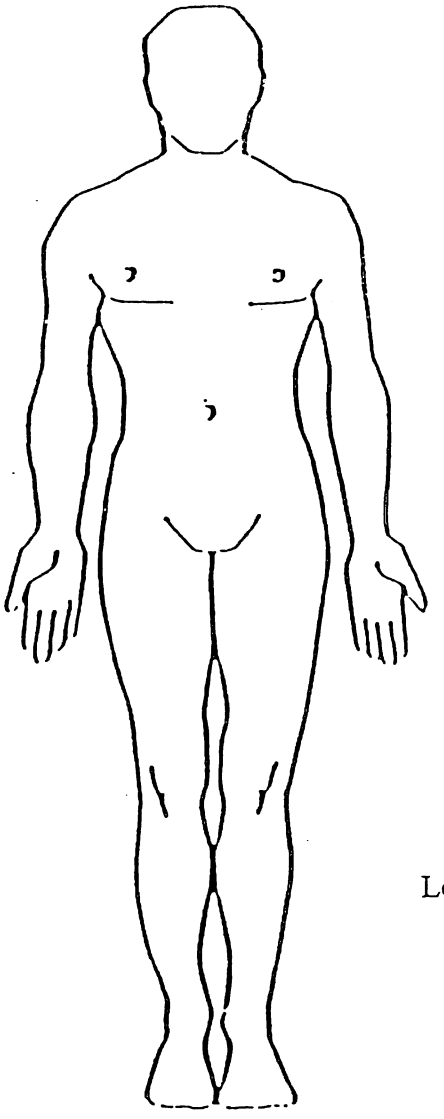
Numbness XXXXX XXXXXXXXX XXXXX

Stabbing SSSSS SSSSSSSSS SSSSS

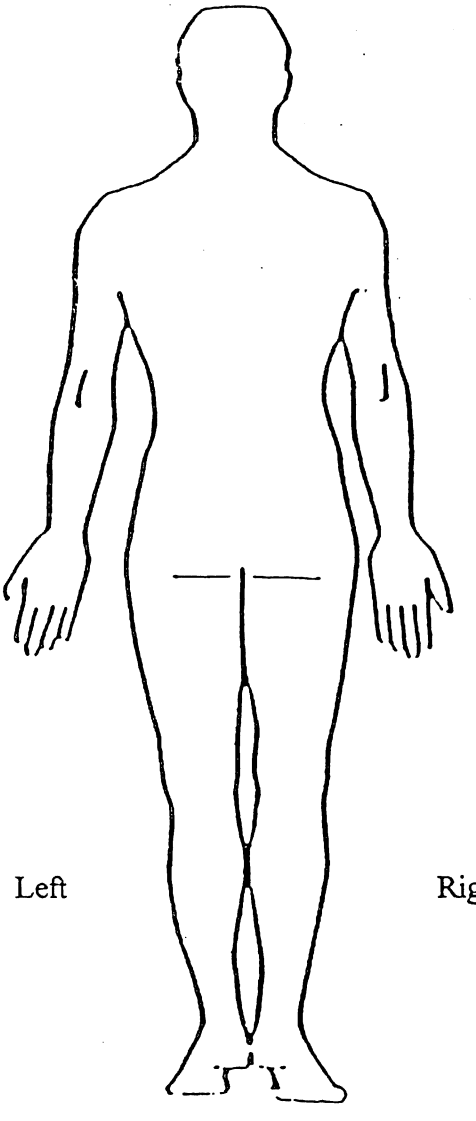
Ache ////////// ////////////////// //////////

Pins and Needles OOOOO OOOOOOOOOO OOOOO

Burning +++++ ++++++++++ +++++



Right Left



Left Right

BROMBERG CHIROPRACTIC

201 Broadway
Cambridge, MA 02139

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

Name of Practice & Provider: Bromberg Chiropractic
Patient Name: _____
Name of Insurer: _____
Date of Injury: _____
Name of Law Office:_____

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 treat me on and after the above date in connection with my injury or illness.

I further grant to my Provider an irrevocable Equitable Lien and an Official Legal Lien as set forth in Ch111§70A through Ch111§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 applicable insurance companies involved with a full report concerning my condition and treatment, including but not 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 treatment services rendered to me.

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

Patients Signature_____ Date: _____

Parent/Guardian Signature: _____ Date: _____