Patient Information
Live Well Chiropractic
171 Wexford Bayne Rd
Wexford, PA 15090
724-940-3900

Name _____ Date _____

Date of Birth____/_____/_____ Age _____ SS# _____

Address _____ City_____ State _____ Zip Code_____

Phone (Cell)_____ Phone (Other) _____

Email_____ Driver's Lic #_____

Sex: Male/ Female Height_____ Weight_____ Dominant Hand: Right /Left

Martial Staus: S M D W

Occupation_____ Work/ School Phone _____

Work/School Address_____City_____ State_____ Zip_____

IN CASE OF EMERGENCY CONTACT

Name_____ Relationship_____

Phone (Cell)_____ Phone (Other) _____

INSURANCE INFORMATION

Car Insurance Company_____

Address_____City_____State_____Zip_____

Claim #_____ Policy #_____

Adjuster_____Phone_____

Full Tort/Limited Tort?

Heatlh Insurance Carrier_____ID #_____

Policy Holder's Name_____ Policy Holder's Birth Date_____

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Name of your Primary Care Doctor_____Phone #_____

Address_____City_____State_____Zip_____

What Law Firm Represents You?_____

Attorney's Name_____

Address_____City_____State_____Zip_____

Name of the Insured on the auto policy_____

Date of Accident_____Date you saw ANY doctor after the accident_____

Cost of all medical treatment since the accident $_____

Please write any Ambulance, Hospital, MD, DC, PT, Dentist, Acupuncturist, etc. since the accident

Name	Phone#	Amount of Bill
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Patient Signature_____

Date_____

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Nature of Accident:
Date of Accident _____Time of Day _____Road Condition_____
Where there any witnesses? Yes/NO Name(s) _____
Were you the: __ Driver __Passenger __Front Seat __Back Seat
Number of people in vehicle? _____Were you wearing seat belts? _____
What direction were you headed? __North __East __South __West
On (Name the Street) _____
What direction was the other car headed? __North __East __South __West
On (Name the Street) _____
Were you struck from: __Behind __Front __Left Side __Right Side
Approximate speed of your car _____mph Other Car _____mph
Were you knocked unconscious? Yes/No If yes, for how long? _____
Were Police notified? Yes/No
In your own words, please describe accident:
_____
_____

Did you have any physical complaints BEFORE the accident? Yes/NO
If yes, please descried in detail: _____

Please describe how you felt:
DURING the accident: _____
IMMEDIATELY AFTER the accident: _____
LATER that day: _____
The NEXTday: _____

Do you have any congenital (from birth) factors which relate to problem? Yes/NO
If yes, please describe: _____
Do you have any previous illnesses which relate to this case? Yes/No
If yes, please describe: _____
Have you ever been involved in an accident before? Yes/NO
If yes, please describe, including dates and type, as well as injuries received:
_____
_____
_____

Where were you taken after accident? _____
Have you been treated by another doctor since the accident? Yes/NO
If yes, please list doctor's name: _____
What type of treatment did you receive? _____
Since this injury occurred, are you symptoms: __Improving __getting Worse __Same

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AUTHORIZATION TO RELEASE MEDICAL INFORMATION/FINANCIAL AGREEMENT

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Chiropractic Clinic will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Chiropractic Clinic 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 or treatment, any fees for professional services rendered me will be immediately due and payable.

I hearby authorized the Doctor to treat my condition as he or she deems appropriate through the use of Chiropractic Care, and I give authority for these procedures to be performed. It is understood and agreed the amount paid by the Doctor, for x-rays, is for examination only and the original x-ray film will remain the property of this office, being on file where they may be seen at any time while a patient of this office. The patient also agrees that he/she is responsible for all bills incurred at this office.

Print Patient Name_____

Patient Signature_____Date_____

Guardian or Spouse's Signature of Authorizing Care_____Date_____

Don't Miss Out!!

Most of our patients bring in their children to get adjusted. If you would like to have your children or spouse evaluated, check the box below and they can each receive a complimentary examination and x-rays (if necessary) if scheduled within 2 weeks of your starting care. This exam is no cost to you and does not obligate them to receive future care. We have several convenient and affordable family payment plans options should family members decide to receive care

☐ *I would like my family members evaluated in the next two weeks.*