CONFIDENTIAL HEALTH INFORMATION

Please allow our staff to photocopy your driver's license and insurance details.
All information you supply is confidential. We comply with all federal privacy standards.
Please print clearly.

Back to Health Chiropractic, P.C.
Dr. Molly (Maureen) Keefe
387 Lake Road Suite 3
Saint Albans, VT 05478
(802) 527-BACK(2225)
www.drmolly.com
Gentle, Effective & Caring

Today's Date (MM/DD/YYYY)

Have you consulted a chiropractor before? ○ No ○ Yes **When?**

Whom may we thank for referring you?

If so, whom?

Gender ○ Male ○ Female

Your Last Name

Your Social Security Number

Your First Name | **Your Middle Name (or Initial)** | **Birth Date (MM/DD/YYYY)**

Marital Status ○ Single ○ Married ○ Divorced ○ Widowed ○ Separated

Address

City | **State/Province** | **ZIP/Postal Code** | **Home Phone** | **Spouse's Name**

Email Address | **Cell Phone** | **Child's Name and Age**

Emergency Contact | **Phone** | **Child's Name and Age**

Your Occupation | **Child's Name and Age**

Your Employer

May we contact you at work? ○ Yes ○ No

Address

City | **State/Province** | **ZIP/Postal Code** | **Work Phone**

Insurance Carrier | **Policy Number** | **Primary Care Provider's Name**

Insured's Last Name

Who carries this policy? ○ Self ○ Spouse ○ Parent

First Name | **Middle Name (or Initial)**

Insured's Employer

Address

City | **State/Province** | **ZIP/Postal Code** | **Employer's Phone**

CONFIDENTIAL HEALTH INFORMATION

1. The symptom(s) that have prompted me to seek care today include: _____

_____

2. And are the result of (darken circle): ○ An accident or injury
○ Work ○ Auto ○ Other _____
○ A worsening long-term problem
○ An interest in: ○ Wellness ○ Other _____

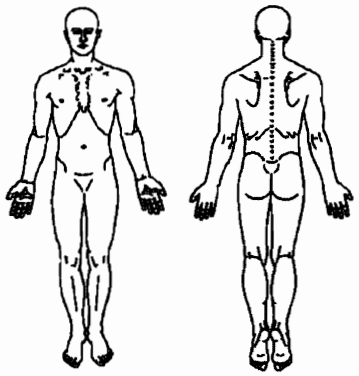
3. Onset (When did you first notice your current symptoms?)
_____

4. Intensity (How extreme are your current symptoms?)
0 ○○○○○○○○○○ 10
Absent Uncomfortable Agonizing

5. Duration and Timing (When did it start and how often do you feel it?)
○ Constant ○ Comes and goes. How Often? _____
_____

6. Quality of symptoms (What does it feel like?)
○ Numbness
○ Tingling
○ Stiffness
○ Dull
○ Aching
○ Cramps
○ Nagging
○ Sharp
○ Burning
○ Shooting
○ Throbbing
○ Stabbing
○ Other _____

7. Location (Where does it hurt?)
Circle the area (s) on the illustration.
"0" for current condition
"X" for conditions experienced in the past



8. Radiation (Does it affect other areas of your body? To what areas does the pain radiate, shoot or travel.)
_____

9. Aggravating or relieving factors (What makes it better or worse, such as time of day, movements, certain activities, etc.)
What tends to worsen the problem? _____
What tends to lessen the problem? _____

10. Prior interventions (What have you done to relieve the symptoms?)
○ Prescription medication ○ Surgery ○ Ice
○ Over-the-counter drugs ○ Acupuncture ○ Heat
○ Homeopathic remedies ○ Chiropractic Other _____
○ Physical therapy ○ Massage _____

11. What else should Dr. Keefe know about your current condition? _____
_____

12. How does your current condition interfere with your:

Work or career: _____

Recreational activities: _____

Household resposibilities: _____

Personal relationships: _____

13. Review of Systems
Chiropractic care focuses on the integrity of your nervous system, which controls and regulates your entire body. Please darken the circle beside any condition that you've **Had** or currently **Have** and initial to the right.

a. Musculoskeletal

Had Have	Had Have	Had Have	Had Have	Had Have	Had Have	
○ ○ Osteoporosis	○ ○ Arthritis	○ ○ Scoliosis	○ ○ Neck pain	○ ○ Back problems	○ ○ Hip disorders	NONE ○
○ ○ Knee injuries	○ ○ Foot/ankle pain	○ ○ Shoulder problems	○ ○ Elbow/wrist pain	○ ○ TMJ issues	○ ○ Poor posture	Initials ____

b. Neurological

Had Have	Had Have	Had Have	Had Have	Had Have	Had Have	
○ ○ Anxiety	○ ○ Depression	○ ○ Headache	○ ○ Dizziness	○ ○ Pins and needles	○ ○ Numbness	NONE ○
						Initials ____

c. Cardiovascular

Had Have	Had Have	Had Have	Had Have	Had Have	Had Have	
○ ○ High blood pressure	○ ○ Low blood pressure	○ ○ High cholesterol	○ ○ Poor circulation	○ ○ Angina	○ ○ Excessive bruising	NONE ○
						Initials ____

d. Respiratory

Had Have	Had Have	Had Have	Had Have	Had Have	Had Have	
○ ○ Asthma	○ ○ Apnea	○ ○ Emphysema	○ ○ Hay fever	○ ○ Shortness of breath	○ ○ Pneumonia	NONE ○
						Initials ____

e. Digestive

Had Have	Had Have	Had Have	Had Have	Had Have	Had Have	
○ ○ Anorexia/bulimia	○ ○ Ulcer	○ ○ Food sensitivities	○ ○ Heartburn	○ ○ Constipation	○ ○ Diarrhea	NONE ○
						Initials ____

f. Sensory

Had Have	Had Have	Had Have	Had Have	Had Have	Had Have	
○ ○ Blurred vision	○ ○ Ringing in ears	○ ○ Hearing loss	○ ○ Chronic ear infection	○ ○ Loss of smell	○ ○ Loss of taste	NONE ○
						Initials ____

g. Integumentary

Had Have	Had Have	Had Have	Had Have	Had Have	Had Have	
○ ○ Skin cancer	○ ○ Psoriasis	○ ○ Eczema	○ ○ Acne	○ ○ Hair loss	○ ○ Rash	NONE ○
						Initials ____

Consultation Notes

Patient name _____

Doctor's Initials _____

Back to Health Chiropractic, P.C.
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(Continued from previous page)

h. Endocrine

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		NONE ○
○	○	Thyroid issues	○	○	Immune disorders	○	○	Hypoglycemia	○	○	Frequent infection	○	○	Swollen glands	○ ○ Low energy

Initials ____

i. Genitourinary

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		NONE ○
○	○	Kidney stones	○	○	Infertility	○	○	Bedwetting	○	○	Prostate issues	○	○	Erectile dysfunction	○ ○ PMS symptoms

Initials ____

j. Constitutional

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		NONE ○
○	○	Fainting	○	○	Low libido	○	○	Poor appetite	○	○	Fatigue	○	○	Sudden weight change	○ ○ Weakness

Initials ____

Patient name _____

○ All other systems negative

Past Personal, Family and Social History

Please identify your past health history, including accidents, injuries, illnesses and treatments. Please complete each section fully.

PERSONAL

14. Illnesses

Check the illnesses you have **Had** in the past or **Have** now.

Had	Have		Had	Have	
○	○	AIDS	○	○	Tuberculosis
○	○	Alcoholism	○	○	Typhoid fever
○	○	Allergies	○	○	Ulcer
○	○	Arteriosclerosis	○	○	Other: _____
○	○	Cancer			
○	○	Chicken pox			
○	○	Diabetes			
○	○	Epilepsy			
○	○	Glaucoma			
○	○	Goiter			
○	○	Gout			
○	○	Heart disease			
○	○	Hepatitis			
○	○	Malaria			
○	○	Measles			
○	○	Multiple Sclerosis			
○	○	Mumps			
○	○	Polio			
○	○	Rheumatic fever			
○	○	Scarlet fever			
○	○	Sexually transmitted disease			
○	○	Stroke			

15. Operations

Surgical interventions, which may or may not have included hospitalization.

- ○ Appendix removal
- ○ Bypass surgery
- ○ Cancer
- ○ Cosmetic surgery
- ○ Elective surgery: _____
- ○ Eye surgery
- ○ Hysterectomy
- ○ Pacemaker
- ○ Spine _____
- ○ Tonsillectomy
- ○ Vasectomy
- ○ Other: _____

16. Treatments

Check the ones you've received in the **Past** or are receiving **Currently**.

Past	Currently	
○	○	Acupuncture
○	○	Antibiotics
○	○	Birth control pills
○	○	Blood transfusions
○	○	Chemotherapy
○	○	Chiropractic care
○	○	Dialysis
○	○	Herbs
○	○	Homeopathy
○	○	Hormone replacement
○	○	Inhaler
○	○	Massage therapy
○	○	Physical therapy
○	○	Nutritional supplements:

List: _____

○ ○ Medications (prescription and over-the-counter):

17. Injuries

Have you ever...

- ○ Had a fractured or broken bone
- ○ Had a spine or nerve disorder
- ○ Been knocked unconscious
- ○ Been injured in an accident
- ○ Used a crutch or other support
- ○ Used neck or back bracing
- ○ Received a tattoo
- ○ Had a body piercing

FAMILY

18. Family History

Some health issues are hereditary. Tell Dr. Keefe about the health of your immediate family members.

Relative	Age (If living)	State of health Good	Poor	Illnesses	Age at death	Cause of death Natural	Illness
Mother		○	○			○	○
Father		○	○			○	○
Sister 1		○	○			○	○
Sister 2		○	○			○	○
Brother 1		○	○			○	○
Brother 2		○	○			○	○
_____		○	○			○	○

19. Are there any other hereditary health issues that you know about? _____

SOCIAL

20. Social History

Tell Dr. Keefe about your health habits and stress levels.

Alcohol use	○ Daily	○ Weekly	How much?	Prayer or meditation?	○ Yes ○ No
Coffee use	○ Daily	○ Weekly	How much?	Job pressure/stress?	○ Yes ○ No
Tobacco use	○ Daily	○ Weekly	How much?	Financial peace?	○ Yes ○ No
Exercising	○ Daily	○ Weekly	How much?	Vaccinated?	○ Yes ○ No
Pain relievers	○ Daily	○ Weekly	How much?	Mercury fillings?	○ Yes ○ No
Soft drinks	○ Daily	○ Weekly	How much?	Recreational drugs?	○ Yes ○ No
Water intake	○ Daily	○ Weekly	How much?		

Hobbies: _____

Consultation Notes

Doctor's Initials _____

Back to Health Chiropractic, P.C.
Dr. Molly (Maureen) Keefe

21. Activities of Daily Living

How does this condition currently interfere with your life and ability to function?

	No Affect	Mild Affect	Moderate Affect	Severe Affect
Sitting	○	○	○	○
Rising out of chair	○	○	○	○
Standing	○	○	○	○
Walking	○	○	○	○
Lying down	○	○	○	○
Bending over	○	○	○	○
Climbing stairs	○	○	○	○
Using a computer	○	○	○	○
Getting in/out of car	○	○	○	○
Driving a car	○	○	○	○
Looking over shoulder	○	○	○	○
Caring for family	○	○	○	○

	No Affect	Mild Affect	Moderate Affect	Severe Affect
Grocery shopping	○	○	○	○
Household chores	○	○	○	○
Lifting objects	○	○	○	○
Reaching overhead	○	○	○	○
Showering or bathing	○	○	○	○
Dressing myself	○	○	○	○
Love life	○	○	○	○
Getting to sleep	○	○	○	○
Staying asleep	○	○	○	○
Concentrating	○	○	○	○
Exercising	○	○	○	○
Yard work	○	○	○	○

22. What is the major stressor in your life? _____

23. How much sleep do you average per night? _____ Hours

24. What is the type and approximate age of your mattress and pillow? _____

25. What is your preferred sleeping position? _____

26. Describe your typical eating habits: ○ Skip breakfast ○ Two meals a day ○ Three meals a day ○ Snacking between meals

27. What would be the most significant thing that you could do to improve your health? _____

28. In addition to the main reason for your visit today, what additional health goals do you have? _____

Acknowledgements

To set clear expectations, improve communications and help you get the best results in the shortest amount of time, please read each statement and initial your agreement.

Initials ____ **I instruct the chiropractor to deliver the care that, in his or her professional judgment, can best help me in the restoration of my health. I also understand that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxation. Chiropractic is a separate and distinct healing art from medicine and does not proclaim to cure any named disease or entity.**

Initials ____ **I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties.**

Initials ____ **I realize that an X-ray examination may be hazardous to an unborn child and I certify that to the best of my knowledge I am not pregnant. Date of last menstrual period (MM/DD/YYYY):** _____

Initials ____ **I grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, emails or health information to me as an extension of my care in this office.**

Initials ____ **I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive.**

Initials ____ **To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.**

If the patient is a minor child, print child's full name: _____

_____ Signature

_____ Date (MM/DD/YYYY)

Patient name

Consultation Notes

Doctor's Initials

Back to Health Chiropractic, P.C.
Dr. Molly (Maureen) Keefe

PRIVACY PRACTICES ACKNOWLEDGEMENT
PATIENCT RECORD OF DISCLOSURES

Acknowledgement Form

In general, the HIPPA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (*PHI*). The individual is also provided the right to request confidential communications or that a communication of *PHI* be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

☐ Home Telephone: _____

- ☐ O.K. to leave message with detailed information
- ☐ Leave message with call-back number only

☐ Work Telephone_____

- ☐ O.K. to leave message with detailed information
- ☐ Leave message with call-back number only

☐ Written Communication

- ☐ O.K. to mail to my home address
- ☐ O.K. to mail to my work/office address
- ☐ O.K. to fax to this number

☐ Other _____

_____

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

_____ _____

Patient Signature Date

_____ _____

Print Name Birthdate

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for *PHI* to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.

Healthcare entities must keep records of *PHI* disclosures. Information provided below, if completed properly, will constitute an adequate health record.

Note: Uses and disclosures for TPO may be permitted without prior consent in an emergency

Back to Health Family Chiropractic

Payment for Services and Supplies Rendered

This is the fun part about our **Financial Policy.** We work hard to keep the cost of chiropractic care down and affordable. You, our wonderful patients, can help us accomplish this by paying your co-pay and any outstanding balances owed at the time of service. The following is a summary of our payment policy.

PAYMENT IS EXPECTED AT THE TIME OF SERVICE

Yes, this is true. We require payment at the time we provide services unless other arrangements have been made in advance. This includes applicable deductibles, co-insurances (your percentage of the balance due) and co-pays for participating insurance companies. We accept cash, local checks, debit cards and credit cards; Visa, MasterCard and Discover. There is a $25.00 service charge for returned checks, and we reserve the right to charge a $5.00 processing/administrative statement fee for non-payment of co-pays at the time of service.

We do understand extenuating circumstances may occasionally cause financial hardship. Please call or speak personally with our Billing Specialist to discuss a reasonable payment agreement.

INSURANCE COVERAGE

At the time of your visit, you will be asked to provide your medical insurance card for correct claim processing. As a courtesy to our patients, we process claims for any insurance group in which we are considered participating providers. (This means we have reached a contractual agreement with them for payment of services Back to Health Chiropractic provides to their members.) You are expected to pay your deductible and co-payments or co-insurance ***at the time of service*** whether we are a participating provider or not. If we have not received payment from your insurance company within 45 days, (2 billing cycles), you will be expected to pay the balance in full. You are ultimately responsible for all charges incurred. If your insurance company denies payment for any reason other than an error on our part, it is ***your*** responsibility to follow up with them to appeal. We will not research denials for you unless it is caused by an error within our office. We will be happy to resubmit charges, once you have researched a solution with a representative from your insurance company.

We will gladly bill secondary insurances if we are on their list of participating providers and you notify us that you have a secondary insurance at the time of service.

If we do not participate with your company, or you cannot provide proof of medical insurance coverage, it is expected you will make payment at the time of service.

REFERRALS

If Dr. Molly determines you need to be seen by a specialist, it is your responsibility to check with your insurance carrier to determine if a Referral or Prior Authorization is required. There are numerous levels of coverage and policy requirements within each carrier/company. Our staff is not responsible for knowing whether or not your policy has these requirements, however; they will help you and your provider process the referral.

MISSED OR "NO SHOW" APPOINTMENTS OR LATE CANCELLATIONS

When you miss a scheduled appointment, or cancel it close to the appointed time, it represents a cost to you, to us and to the other patients. We request 24 hour notice if you can not make an appointment. We reserve the right to charge a $25.00 fee for missed or late cancelled appointments. If the late cancellation is due to an emergency or the weather, there would be no charge. A no-show appt is subject to a $50 charge. Excessive missed or "no-show" appointments will sadly result in discharge from the Back to Health practice.

CUSTODIAL PARENTS

By law, you are responsible for payment of your child's medical bills, even if you are not the subscriber of the insurance policy that covers your child's medical services.

SIGNATURE

I have read and understand Back to Health Family Chiropractic's Financial Policy. I agree I am responsible for the balance of my account for any professional chiropractic services rendered. I certify the patient information given is true and accurate to the best of my knowledge. I also agree that if it becomes necessary to forward my account to a collection agency, I will be responsible for any fees incurred by the collection agency, in addition to any amount owed for services.

_____ _____

Signature of insured / responsible representative Date

_____ _____

Witness Date

Back to Health Family Chiropractic

Instructions: Fill in Your Name and Name of All Drugs and Vitamins/Supplements You are taking

Patient: _____

(for office Use Only Italic Categories) *ordered*

DRUG	*Depletes/Interfers with*	*Cost*	*YES*	*NO*
Name:				
Purpose:				
Name:				
Purpose:				
Name:				
Purpose:				
Name:				
Purpose:				
Name:				
Purpose:				
Name:				
Purpose:				
Name:				
Purpose:				

Vitamin/Supplement	HELPFUL (circle one)		Patient Comments
Name:	Yes	No	
Purpose:	Somewhat	I don't know	
Name:	Yes	No	
Purpose:	Somewhat	I don't know	
Name:	Yes	No	
Purpose:	Somewhat	I don't know	
Name:	Yes	No	
Purpose:	Somewhat	I don't know	
Name:	Yes	No	
Purpose:	Somewhat	I don't know	
Name:	Yes	No	
Purpose:	Somewhat	I don't know	

AUTOMOBILE ACCIDENT HISTORY

AUTOMOBILE ACCIDENT:

Name _____ Sex M / F Age: _____

Address _____ Driver's License # _____

GENERAL SYMPTOMS:

Did you hit any part of your body during the collision, for example, head on the dash, chest on steering wheel ? Y / N

If Yes, which part and how? _____

Where you taken after the accident? _____

Were you hospitalized? Y / N When did you go? _____ If yes, how did you get there? _____

If by ambulance, did the ambulance attendants place you in a ____ neck brace ____ back brace ___ other_____

Any medications or medical supplies given? _____

Did you have x-rays, CT, MRI taken? Y / N When? _____ Where? _____

How long were you there? _____

Did you receive care from any other health care specialist? Y / N ? If yes , who? _____

What type of care were you given and for how long? _____

Immediately after the accident were you ____conscious ____dazed/confused ___unconscious
If unconscious for how long? _____

Where did you feel the pain initially? _____ 72 hours later?_____

What are your current symptoms? _____

Have you ever been injured in a similar manner? Y / N If yes, how and when? _____

_____

ACCIDENT HISTORY:

Date and Time: _____

State How Accident Happened in your own words_____

_____

_____

Were you driving? Y / N Passenger? Y/ N Pediatrian? Y / N
Was it your car? Y / N If not who's car was it? _____

Passenger? Y / N Were you in the Front? Back? right middle or left side? _____

At the time of impact were you: ____looking straight ahead ____ looking to the right ____ looking to the left
___ looking down ____ looking up

AUTOMOBILE ACCIDENT HISTORY(cont.)

Was your vehicle shoved: ___ forward ____ backward ___sideways

Did your vehicle hit: _____another car ____ a sign __ guard rails ___ bridge ___other _____

Were you shoved: ____ forward ___backward ___sideways

Did your seat have a head restraint(headrest?) Y / N If yes, what position: ____low _____midposition _____high

Did your head ride over the headrest? Y / N Did your hat/glasses end up in the back seat or rear window? Y / N

Did any other part of your body hit the interior of the vehicle? Y/ N if yes please specify: ____ seatbelt restraints

___ steering wheel ___ dashboard ___ windshield ___side door ___ side window ___ other _____

Were you holding the steering wheel? Y / N Did you brace your arms Y/ N ____steering wheel ___ dash

Were you surprised by the impact? Y / N

Did you brace your legs against the floorboard? Y /N Was your ankle turned? Y / N

Did the vehicle go into a spin or roll as a result of the impact? Y / N
How much damage to the outside of your vehicle? _____ none _____ some ___ a lot ___ totaled
How much damage to the other vehicle? _____ none _____ some ___ a lot ___ totaled
Other people in car: Name and Address: _____
_____
_____

Other vehicle ? __ car ___ truck __ motorcycle ___ other _____

Who was ticketed? _____ why? _____

Seat Belt On? Y / N Shoulder harness on? Y / N Did the seat belt break? Y/ N Did it contribute to your pain? Y/N

Was it daylight, night, dusk or dawn? _____

Were you tired? Y / N Were you awake? Y / N How long had you been in the car? _____

Where were you prior to the accident? _____ What was the weather conditions? _____

_____ Traffic conditions? _____

What was the posted speed limit? _____ How fast were you going? _____ The other car? _____

Was your vehicle in: ___ park ___ neutral ___ in gear ___ moving ___ stopped

Were your brakes being applied? Y / N

Type of Road: Two Lane _____ Four Lane ____ Gravel _____ Tar ____ One Way _____ Divided _____

Did it happen at: _____ a stop sign? _____ traffic light? _____ at an intersection? ___ other? _____

Was your car hit? ___Front __ Back __Left side front ___Left side Back ___Right side front ___Right side back

What damage was done to your car? Inside _____

Outside_____

Other_____

AUTOMOBILE ACCIDENT HISTORY(cont.)

If you struck another car, did you strike it: ____Front ____ Back ___Side

What was the damage to the other car? Inside _____

Outside _____

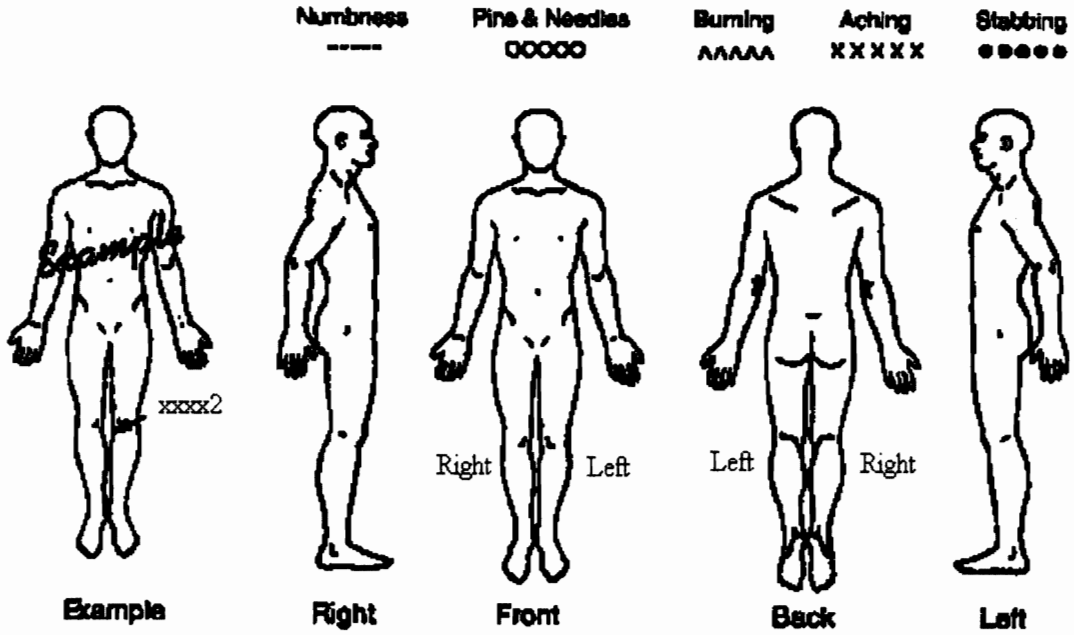
Have you lost time from work? Y / N If yes how long? _____ Does it bother you to ride in a car now? Y/ N

ATTORNEY INFORMATION

Do you have an attorney: Y / N If yes: Name, address and phone number: _____

_____

Please fill out the diagram as you feel currently



Patient Signature: _____ Date: _____

Print Name : _____

Witness: _____ Date: _____

Date: _____
Patient Name: _____
Cert. No.: _____
Date of Service: _____
Provider: _____

If you check **YES** in any of the boxes below, complete the applicable column in **Sections A & B**
If you check **NO** in any of the boxes below, complete **Section B Only**.

SECTION A

Work Related: ☐ Yes ☐ No (Complete questions below if YES)	**Auto Related:** ☐ Yes ☐ No (Complete questions below if YES)	**Other Injuries:** ☐ Yes ☐ No (Complete questions below if YES)
Was condition reported to Patient's employer? ☐ Yes ☐ No	**Was the patient a:** ☐ Driver ☐ Pedestrian ☐ Passenger ☐ Other: _____	Was patient's condition a result of: ☐ a defective product ☐ an animal bite ☐ a slip and fall ☐ occurred on someone else's property ☐ other (explain) _____ _____ _____ (use reverse if necessary)
Has patient filed an accidental injury claim with employer or the Worker's Comp. Insurance Carrier? ☐ Yes ☐ No If yes, has the claim been ☐ Accepted ☐ Denied ☐ Other (explain) _____ _____	**Number of vehicles involved** _____ **Where accident occurred:** Street: _____ City: _____ State: _____ **If passenger, driver's name & address:** Driver's Name: _____ Address: _____ _____ **Driver's Insurance Info.:** Co. Name: _____ Address: _____ _____ **Do you intend to make a claim against the responsible person?** ☐ Yes ☐ No **Person Responsible for Accident:** Name: _____ Address: _____ _____ **Ins. Info. of responsible person:** Name: _____ Address: _____ _____	Was another party responsible for this accident? ☐ Yes ☐ No **Person Responsible for Accident:** Name: _____ Address: _____ _____ **Ins. Info. of responsible person:** Name: _____ Address: _____ _____ **Policy Claim #:** _____ _____
Employer Information: Name: _____ Address: _____ _____ Phone: _____		
W/C Insurance Carrier Information: Name: _____ Address: _____ _____		
Are you exempt from Workers Comp under State/Federal Law? ☐ Yes ☐ No ☐ Other (explain) _____ _____		

SECTION B

Date of Accident or Injury: _____

Description of accident/injury (use back of this form if necessary) _____
_____
_____

Have you hired an attorney? ☐ Yes ☐ No If yes, please document name, address, phone number below
Name: _____
Address: _____
Phone: _____

Please indicate a phone number where you can be reached for further questions: Tel: _____
I certify the above information is true to best of my knowledge:
Signature: _____ Date: _____

FAILURE TO RESPOND COULD DELAY THE PROCESSING OF YOUR CLAIMS!!!!!