Workers' Compensation Questionnaire

Please answer all questions completely

Dear Patient: This information is considered confidential. We need this information because we care enough to want to know, and your answers will help us determine if chiropractic can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. In order for us to understand your condition properly, please be as neat and accurate as possible while completing this form. Thank you.

Name _____ Sex _____ Marital Status _____ Date of Birth _____ Home Phone _____

Address _____ City _____ State _____ Zip _____

Occupation _____ Who referred you to our office? _____
(Indicate if child, student, housewife, unemployed, retired)

Social Sec. # _____ Business Phone _____ Company Name _____ Location _____

Spouse's First Name _____ Spouse's Soc. Sec. # _____ Spouse's Employer _____ Location _____

Please explain in detail how your accident happened _____

_____

_____

_____

_____

Have you retained an attorney? ☐ Yes ☐ No Litigation? ☐ Yes ☐ No ☐ Maybe

If so, name and address _____

Give time and date present injury occurred _____ ☐ AM ☐ PM _____ 19_____

Where did you feel pain immediately after the accident? _____

Did you return to work? ☐ Yes ☐ No If so, date returned to work _____

Did you consult any other doctor? ☐ Yes ☐ No

If so, give doctor's name _____ ☐ D.C., ☐ M.D., ☐ D.O., ☐ D.D.S.

Doctor's diagnosis _____

What treatments did you receive? _____

Have you ever injured this area before? ☐ Yes ☐ No If so, when? _____

If injured before, did you lose time from work? ☐ Yes ☐ No

If you lost time from work with injuries prior to this injury, give name of doctor or doctors consulted _____

_____

Do any other diseases or accidents affect your employment? ☐ Yes ☐ No If so, explain _____

_____

In your work do you have to favor any part of your body? ☐ Yes ☐ No If so, explain _____

_____

Do you have a history of absenteeism caused from accidents on the job? ☐ Yes ☐ No

Have you ever had a Workmen's Compensation claim before? ☐ Yes ☐ No

Before the injury were you capable of working on an equal basis with others your age? ☐ Yes ☐ No

Are your work activities restricted as a result of this accident? ☐ Yes ☐ No

Since this injury are your symptoms ☐ improving? ☐ getting worse? ☐ the same?

DOCTOR'S LIEN
AND INSTRUCTIONS TO COUNSEL

I, the undersigned, understand that all past, present and future bills incurred at the Doctor/Clinic noted below, are my responsibility for payment. I hereby ratify my agreement to pay all bills incurred during my health care at this Clinic.

In consideration for the below named Doctor/Clinic having agreed to treat me without payment at the time of service and enabling me to obtain treatment for my accident/injury/illness, without financial hardship, I give you a lien on any settlement, claim, judgment, verdict or result of said accident/injury/illness and I agree to irrevocably instruct my attorney to pay you in full from any proceeds of settlement, claim or judgment related to this accident/ injury/illness.

I also understand that if the settlement does not cover my entire bill at this Clinic, I am still responsible for the remainder and the payment by me of this bill is not contingent on any settlement, claim or judgment which I may eventually recover.

Furthermore, in consideration for the below named Doctor/Clinic refraining from attempting to collect immediate payment for services rendered for my accident/injury/illness, I do hereby waive and toll any applicable statute of limitations on the collection of my account until I notify the Doctor/Clinic of the conclusion of my efforts to obtain a settlement or judgment through the assistance of my attorney and for a period of three (3) months thereafter.

DR. CHRISTOPHER ALEXANDER
270 WEST CHURCH ST., SUITE E
LEXINGTON, TN 38351

Doctor/Clinic Name and Address

_____
Patient Name (Please Print)

_____
Patient Signature

_____
Date

* * * * *

INSTRUCTIONS TO COUNSEL

I do hereby irrevocably instruct you, my Attorney, named below, to pay Doctor/Clinic named above in full for services to me for my accident/injury/illness from any proceeds of settlement, claim or judgment regarding said accident/injury/illness. You are to pay the Doctor/Clinic prior to distributing any proceeds to me and I instruct you not to attempt to reduce by means of negotiation my doctor's bill for the services that have been provided to me for the accident/injury/illness which I have agreed to pay in full.

_____
Firm Name

_____
Patient Signature

_____
Attorney Name

_____
Date

* * * * *

ATTORNEY'S ACCEPTANCE OF LIEN

Being the attorney of record or authorized representative, I acknowledge receipt of my client's instructions to Counsel and Lien and agree to honor the same.

_____
Attorney Signature

_____
Date