Patient Insurance Form Date: ___/___/20___
Please fill out the following information completely. If you have any questions, a staff member will be happy to assist you.

Perrault Chiropractic Offices, Inc., Phone: 978-686-7791
76 Woodland Street, Methuen, MA Fax: 978-975-0468
For office use: Dr ______ Sx ___ Code _____ FC _____ F ____

Name: First ____________________ MI ___ Last ____________________________________ **Birth Date** ___/___/_______
Employer:_____________________________________ Years ______ Job Title ______________________________
Employer's Address: ____ City: ________________ State: _____ Zip: _______

Health Insurance Information. We will require a copy of your insurance card(s) to verify coverage.

Primary Insurance: Company: _________________________ Policy #: __________________________________
Group #: __________________________ Deductible: $ __________ Co-Pay _____________
Who is the policy holder?: ❑ Self ❑ Spouse ❑ Parent ❑ Other
If the policyholder is other than self – Please supply the following information about the policyholder:
Name: First ____________________ MI _____ Last ___________________________ **Birth Date** ___/___/_______
Social Security ________-_____-________ **Phone:** (_____) _____-_________ **Relationship:** ____________________
Address: _______________________________________ City: ________________ State: ______ Zip: _________
Employer: ____

Secondary Insurance: Company: _________________________ Policy #: __________________________________
Group #: __________________________ Deductible: $ __________ Co-Pay _____________
Who is the policy holder?: ❑ Self ❑ Spouse ❑ Parent ❑ Other
If the policyholder is other than self – Please supply the following information about the policyholder:
Name: First ____________________ MI _____ Last ___________________________ **Birth Date** ___/___/_______
Social Security ________-_____-________ **Phone:** (_____) _____-_________ **Relationship:** ____________________
Address: _______________________________________ City: ________________ State: ______ Zip: _________
Employer: ____

Is your condition due to an injury? ❑ Yes ❑ No If "No" you are done with this form. If "Yes" complete the following:
Injury caused by: ❑ auto accident ❑ work injury ❑ at home ❑ other Date of injury: _____/_____/_________
Where did the injury occur? ____ City: ____________________ State: ______
Did you lose time from work? ❑ Yes ❑ No If yes: First date out _____/_____/_________ Date returned _____/_____/________

Auto Accident Injury

Police at the accident scene? ❑ Yes ❑ No
Accident report filed by you? ❑ Yes ❑ No Date ___/___/___
Car owner: ____
Relationship to owner: ______________________________
Driver: ____
Relationship to Driver: ______________________________
Auto Insurance Company: ____________________________
Policy number: ____________________________________

Work Related Injury

Did you file a report with your employer? ❑ Yes ❑ No
When did you report the injury? _____/_____/_________
Reported to whom? ____________________________
What is that person's title? _________________________
Have you received a *Utilization & Review* (UR) card from your employer? ❑ Yes ❑ No
Massachusetts workers injured on the job are required to present the UR to their healthcare provider as soon as they receive it.

For office use: **Dx1** _________ **Dx2** _________ **Dx3** _________ **Dx4** _________ **Dx5** _________ **Dx6** _________
X-Ray _____/_____/20_____ Consult _____/_____/20_____ DOI _____/_____/_________
INS1 ___________ INS2 ___________ INS3 ___________ Atty.: _______________
Treating Dr. __________________ Referring Dr. ________________________ File # __ __ __ __ __ __