MAURICIO CHIROPRACTIC APPLICATION FORM

Select One: ☐ Auto Accident ☐ Slip & Fall ☐ Work Related Injury ☐ Private Health ☐ Other:

Date: ________ Home Telephone: ________________ Cell Phone: ________________

Name: ____

Address: ____

City: ________________ State: ________________ Zip: ________

Email: ____

Date of Birth: ________ Age: ________ Gender: ________ SSN: ________

In case of Emergency we should contact: ________________ Phone: ________________

Employer: ________________________ Phone: ________________

Occupation: ________________ Marital Status: ☐ S ☐ M ☐ W ☐ D

Accident Date: ________ State: ________ Brief Description of the Accident: ________

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Where you wearing a seat belt? ☐ Yes ☐ No ☐ N/A

Did you go to the hospital? ☐ Yes ☐ No ☐ N/A If yes, Name of the Hospital: ________

X-Rays Taken? ☐ Yes ☐ No ☐ N/A

Have you lost time from work? ☐ Yes ☐ No Are you still off work? ☐ Yes ☐ No ☐ N/A

If yes, indicate dates lost: From: ________________ To: ________________

Primary Care Physician: ________________ Tel#: ________________

Have you been involved in any previous accidents? ☐ Yes ☐ No What Year: ________

If yes explain: ____

____

Present Complaints (Please be Specific: ____

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☐ Mauricio Chiropractic Downtown
205 East Colonial Drive
Orlando, FL 32801

☐ Mauricio Chiropractic Dr, Phillips
7601 Conroy-Windemere Road
#204
Orlando, FL 32835

☐ Mauricio Chiropractic Conway
4747 S. Conway Road Ste A
Orlando, FL 32812

☐ Mauricio Chiropractic Winter Park
1810 Semoran Blvd Ste 104
Winter Park, FL 32792

☐ Mauricio Chiropractic Pine Hills
1050 Pine Hills Road
Orlando, FL 32808

☐ Mauricio Chiropractic E. Colonial
12278 E. Colonial Dr. Ste 700
Orlando, FL 32826

☐ Mauricio Chiropractic South OBT
12720 S. Orange Blossom Trail #20
Orlando, FL 32837

☐ Mauricio Chiropractic Poinciana
860 Towne Center Drive
Kissimmee, FL 34759

Legal Representation: ☐ N/A

Attorney's Name: ______________________ Tel: ______________________

Address: ____

Auto Insurance Information: ☐ N/A

Company Name: ______________________ Adjuster: ______________________

Policy#: ______________________ Claim#: ______________________

Private Health Insurance Information: ☐ N/A

Company Name: ______________________ Insured: ______________________

Relation to insured: ______________________ Group#: ______________________

Policy#: ______________________ Phone#: ______________________

Is there any additional insurance? ☐ Yes ☐ No Please answer the following information:

Company Name: ______________________ Tel: ______________________

Insure Name: ______________________ Relation to the patient: ______________________

Have you been solicited by an individual concerning this accident? ☐ Yes ☐ No ☐ N/A

If yes, please explain: ____

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PLEASE READ AND SIGN

I hereby authorize any physical, hospital, pharmacy, insurance company, employer, or organization to release any and all medical information history, records diagnosis, records or z-rays in your possession concerning the undersigned to Mauricio Chiropractic, LLC, or treating doctor. A photocopy of this authorization shall be valid as the original.

AUTHORIZATION AND ASSIGNMENT: I hereby authorize my insurance company to pay direct to Mauricio Chiropractic, LLC the expenses benefits allowable, and otherwise payable to me under my current insurance policy, as payment toward the total charges for professional services rendered. This payment shall not exceed my indebtedness to the above-mentioned assignee and I have agreed to pay, in a current manner, any balance for said professional services charges over and above this insurance payment.

DOCTORS LIEN: I do hereby authorize the above doctor to furnish you, my attorney, with a full report of his examination diagnosis, treatment, prognosis, etc., of myself in regard to the accident in which I was involved.

I hereby authorize and direct you, my attorney, to pay directly to paid doctor such sums may be due and owing him for medical services rendered me both by reason of this accident and by reason of any other bills that are due his office and to withhold such sums from any settlement, judgment, or verdict as may be necessary to adequately protect said doctor.

And I hereby further give a lien on my case to said doctor against any and all proceeds of any settlement, judgment, or verdict which may be paid to you, my attorney, or myself as a result of the injuries for which I have been treated or injuries in connection therewith.

I fully understand that I am directly and fully responsible to paid doctor for all medical bills submitted by him for services rendered to me and that this agreement is made solely for paid doctor's additional protection and in consideration of his awaiting payment. And I further understand that such payment is not contingent on any settlement, judgment, or verdict by which I may eventually recover paid fee.

Print: ______________________ Guardian: ______________________

Signature: ______________________ Date: ______________________