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 # __ __ __ __ __ __