Warwick Brain & Spine Therapy
Dr. Calvin Hargis, Board Certified Chiropractic Orthopedist

40 Maple Avenue, Route 94
Warwick, NY 10990
845-986-5500

Worker's Comp Questionnaire

Patient Name ______________________ Injury Date __________ Time ________ AM PM

Patient Address ______________________________

Birth Date __________ Social Security __________ Phone __________

Married ______ Single ______ Divorced ______ Widowed ______ Separated ______

Employer Name ______ Employer Phone ______________________

Employer Address ______________________________

Employer's Insurance Carrier ______________________________

Insurance Carrier's Address ______________________________

Insurance Carrier's Phone __________ Carrier's Case # __________

WCB# ______________________

Describe Your Normal Job Duties: ______________________________

____

____

Describe the accident and what was injured ______________________________

____

____

Where were you when the injury occurred (State)? ______________________________

Did you go to the hospital? ______ Which? ______________________

Did you see a doctor? ______ List ______________________

Did you have a CT, MRI, X-Ray or other test? ______________________________

Are you working? __________ If no, explain ______________________

Did you miss time from work originally? __________ How long? __________

Did you report the injury? ______ Name of that person ______________________

Describe any prior health problems ______________________________

____

____

Describe prior accidents/injuries (Workers Comp or others) ______________________________

____

____

List your complaints related to this injury

1. ______________________________
2. ______________________________
3. ______________________________

We will submit your bills to your insurance carrier. However you are responsible for all charge not covered by your insurance carrier. Balances more than 2 months old are accessed an interest rate of 1.5% per month.

Patient Signature: ______________________ ______________________

WARWICK BRAIN & SPINE THERAPY
Dr. Calvin Hargis, Board Certified Chiropractic Orthopedist

40 MAPLE AVENUE, ROUTE 94
WARWICK, NY 10990
845-986-5500

No Fault Information Sheet

Patient Name ______________________________ SS # __________

Patient Address ____________________ City ______________ ZIP __________

Birth Date ____________ Phone: ____________ Cell Phone ____________ Email: __________

NO FAULT CLAIM #: ____________ INJURY DATE: __________ Policyholder Name: __________

Insurance Company: ______________ Street: __________ City: ____________ State: ______

Zip: ________ Phone: __________ Insurance Adjuster's Name ____________________

Have you returned the No Fault Application to the Ins Co? Yes No If yes, when? ______________

What state did the accident occur in? ____________ Road conditions? __________ Time? __________

Vehicle you were in? ______________________ Other vehicle type/s? ______________

Seat belt on? Y N Air bags deployed? Y N Did you strike anything inside the vehicle? ______________

____

Did you go to the hospital? Y N By car or ambulance? __________ Were you admitted? Y N __________

Date of admittance from ________ to ________ What doctors, tests or x-rays have you had, where and when?

____

____

Have you missed time from work? Y N If yes, dates from ________ to ________ Other ____________

Describe the Accident? ____

____

____

Were you or the other driver ticketed? Y N Explain: ______________________________

____

____________ Attorney's name and address if you have legal representation: ______________

Phone: ____

As a courtesy to our patients bills are submitted to your insurance carrier. Payment for fees not covered by your insurance carrier are your responsibility. Balances over 2 months old are accessed an interest rate of 1.5% per month from the time of service.

I have read this document and agree to its stipulations and further state that the statements herein are true to the best of my knowledge as avowed by my signature below.

Printed Patient Name ______________________ Date: ______________________

Patients's Full Signature ____

Witness Signature ______________________ Date: ______________________