KATZ CHIROPRACTIC & REHABILITATION CLINIC
FRONT RANGE DIGITAL MOTION X-RAY
954 North Street, 2nd Floor, Boulder, CO 80304 Office: 303/938-9070 Fax: 303/938-9170

Patient Information

Name: Last________________________First________________MI_____Date_____________
Your Current address____
City________________________State_____________Zip______________________________
Phone H____________________W_______________________cell______________________
Social Security____________________________Male____Female____Student_____________
Date of Birth: month______day____year______Driver's License______________________
Permanent address____
City_________________________State_____________________Zip____________________
Employer__________________________________Occupation___________________________
Employer address____

General Information *Date of onset of problem________Surgery date____________*
Referring Doctor______________________________PHP______________________________
Address of PHP____
Description of problem____
Ongoing problem or new?_________________Work accident____Auto____Other_________

General Insurance Company:____
Subscriber #___________________________Phone #______________________________
Address____
Guarantor____

If Work Comp: Claim #____
Adjusters Name_________________________________Phone#______________________
Insurance Company Name____
Address____

If Auto: Type of Accident________________________Date of Accident__________________
Has Fault been Established? Your's_______ Other______
If accident is your fault, fill out your Auto Insurance section. If not, fill out AT-Fault Driver's insurance section.

At Fault Driver's Insurance Co.____
Adjuster_______________________________Phone#_____________________________
Policy Holder's Name______________________________Claim #____________________

Your Auto Insurance Co.____
Adjuster___________________________________Phone#_________________________
Claim #_______________________________

Do you have an Attorney?_________May we have permission to speak with him/her regarding your treatment and payment at Katz Chiropractic & Rehab. Clinic/ Front Range Digital Motion X-Ray? Yes_____ No______ Lien:___Yes ___No

If yes, Name_______________________________________Phone#_____________________