Dean Insana, D.C.
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CONFIDENTIAL NEW PATIENT QUESTIONNAIRE

PATIENT INFORMATION

REFERRED BY: _____ Email _____
1. LAST NAME _____ FIRST NAME _____ 3. MI _____
4. ADDRESS _____
5. CITY _____ 6. STATE _____ 7. ZIP_____
8. HOME (_____) _____ 9. WORK (_____)_____ 10. CELL (_____) _____
11. AGE ____ 12. DATE OF BIRTH _____/_____/_____ 13. SEX ☐ M ☐ F 14. SOC. SEC.# _____-_____-_____
15. MARITAL STATUS ☐ S ☐ M ☐ D ☐ W 16. SPOUSE'S NAME _____
18. PRIMARY CARE PHYSICIAN:_____
ADDRESS:_____
TELEPHONE: (_____) _____ FAX: (_____) _____

FILL ONLY IF: WORKERS COMPENSATION / SCHEDULED LOSS INFORMATION

2. EMPLOYER & OCCUPATION _____
2. ADDRESS _____
3. CITY _____ 4. STATE _____ 5. ZIP _____
8. BUSINESS PHONE # (_____) _____ 9. FAX # (_____)_____
10. **(SCH. LOSS EXAMS)** DO YOU HAVE: ☐ SURGICAL REPORTS ☐ X-RAY REPORTS ☐ MRI REPORTS

FILL ONLY IF: AUTO INJURY / WORK INJURY / PERSONAL INJURY INFORMATION

1. INSURANCE TYPE: ☐ AUTO ☐ WORK ☐ LIEN ☐ _____
2. PATIENT'S RELATIONSHIP TO INSURED: ☐ SELF ☐ SPOUSE ☐ CHILD ☐ _____
3. DATE OF INJURY _____ 4. DESCRIBE HOW INJURY OCCURED? _____
_____
6. WHICH BODY PART(S) WERE INJURED? _____
7. NAME OF INS. CO. _____ 8. INS. PHONE (_____)_____
9. INS. CO. ADDRESS _____
10. POLICY # _____ 11. CLAIM # _____ 12. WCB #_____
13. DID YOU REPORT INJURY? ☐ NO ☐ YES IF YES, TO WHOM?_____
14. HOSPITALIZED? ☐ NO ☐ YES WHERE?_____ 15. X-RAYS TAKEN ☐ NO ☐ YES BY WHOM _____
16. WHERE YOU WORKING AT THE TIME OF THE ACCIDENT? ☐ NO ☐ YES
17. ARE YOU PRESENTLY WORKING? ☐ NO ☐ YES IF NO, DATES LOST FROM WORK _____
18. NAMES OF OTHER DOCTORS SEEN FOR THIS INJURY _____
19. IF AUTO INJURY, WERE YOU? ☐ DRIVER ☐ PASSENGER ☐ PEDESTRIAN ☐_____
20. # OF PEOPLE IN YOUR VEHICLE? _____ 21. WORE SEAT BELT? ☐ NO ☐ YES 22. DID AIRBAG INFLATE ☐ NO ☐YES
23. NAME OF ATTORNEY _____
ATTORNEY ADDRESS:_____
ATTORNEY TELEPHONE: (_____) _____ ATTORNEY FAX: (_____) _____

PRIVATE HEALTH / MEDICARE INSURANCE INFORMATION

1. INSURED'S NAME _____ 2. INSURED'S SS# _____/_____/_____
3. PATIENT'S RELATIONSHIP TO INSURED: ☐ SELF ☐ SPOUSE ☐ CHILD ☐ _____
4. NAME OF INSURANCE CO. _____
5. ADDRESS _____
6. INSURANCE PHONE # (_____)_____ 7. POLICY # _____
SECONDARY INSURANCE 8. INSURED'S NAME _____ 9. SS # _____/_____/_____
10. NAME IS INSURANCE CO. _____
11. ADDRESS _____
12. INSURANCE PHONE # (_____) _____ 8. POLICY # _____