George J. Costanzo, D.C.
340 North Main Street
Southington, CT. 06489
(860) 621-0131

PLEASE SUPPLY US WITH A COPY OF YOUR DRIVERS LICENSE

NAME: ________________________________ DATE:____________________
FIRST MIDDLE LAST
ADDRESS: _________________________ CITY: ______________ ZIP:______
S.S. #: ___________________ D.O.B. ____________PHONE:______________
MARITAL STATUS: _________________ NUMBER OF CHILDREN: _________
EMPLOYER'S NAME: _____________________ WORK PHONE: ___________
ADDRESS: _________________________ CITY: _____________ ZIP: _______
FAMILY DOCTOR'S NAME: ____________ ADDRESS: __________________

FILL OUT THE SECTION(S) THAT PERTAIN TO YOUR CARE

HEALTH INSURANCE
INSURANCE NAME: ____
PHONE: ______________________ **POLICY #:** ______________________
GROUP # ______________________ **INSURED:**______________________
IF OTHER THAN SELF, RELATION: _____________ D.O.B. _____________
S.S. # OF POLICY HOLDER: _____________________________________

AUTO ACCIDENT
DATE OF ACCIDENT: __________________ REPORT MADE:____________
AUTO INSURANCE COMPANY: ___________________CLAIM #:__________
ADDRESS: ____________________ CITY: ________________ ZIP: ________
PHONE: ______________________ POLICY #: _________________________
ATTORNEY'S NAME & PHONE #:____________________________________

WORK INJURY(WORKMAN'S COMPENSATION)
DATE OF INJURY: _________________________
EMPLOYER'S NAME: ______________________
ADDRESS: _________________________ CITY: _____________ ZIP: _______
WORK PHONE: ____________________ S.S. #: _________________________
CONTACT NAME: _________________________

****
IF YOUR INSURANCE REQUIRES A REFERRAL, PLEASE NOTE IT IS YOUR RESPONSIBILITY TO OBTAIN ONE FROM YOUR PRIMARY CARE DOCTOR
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PLEASE FILL OUT REVERSE SIDE

MAJOR COMPLAINTS AND SYMPTOMS: ________________________________
HOW DID YOUR INJURY OCCUR? ________________________________
HAVE YOU LOST ANY DAYS FROM WORK?: ____________________________
ARE YOU ON ANY MEDICATION?: ________________________________
DO YOU HAVE A PACEMAKER?: ________________________________
HAVE YOU EVER HAD X-RAYS? WHEN______________ WHERE__:___________

FOR WOMEN:
TO THE BEST OF YOUR KNOWLEDGE, IS THERE ANY CHANCE THAT YOU ARE PREGNANT?:_________

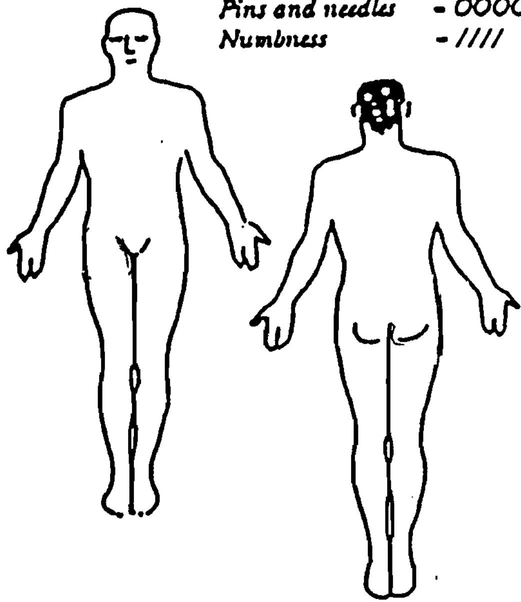
PLEASE CHECK ANY OF THE FOLLOWING DISEASES THAT YOU HAVE NOW, OR HAVE HAD:

DIABETES( ) TUBERCULOSIS( )
HYPERTENSION( ) HEART DISEASE ( )
ARTHRITIS( ) STROKE( ) CANCER( )
EPILEPSY( ) ASTHMA( )
MENSTRUAL PROBLEMS( )

PLEASE CHECK ANY OF THE FOLLOWING SYMPTOMS YOU HAVE NOW:

FEVER( ) HEADACHES( ) CHILLS( ) SWEATS( )
CHEST PAIN( ) CONSTIPATION( )
INABILITY TO CONTROL BOWEL( )
FREQUENT URINATION URINARY CHANGES( )
INABILITY TO CONTROL URINE DIARRHEA( )
PROSTATE TROUBLE( ) NUMBNESS IN ARMS OR LEGS( )

PAIN DRAWING
Please indicate the appropriate location of pain and the symbol that best describes the discomfort you are presently experiencing.



I hereby authorize release of information necessary to file a claim with my insurance company and or attorney and ASSIGN BENEFITS OTHERWISE PAYABLE TO ME TO THE DOCTOR OR GROUP INDICATED ON THE CLAIM.

I understand that I am financially responsible for any balance not covered by my insurance company.

A copy of this signature is valid as the original.

________________________________ ______________________
(Signature) (Date)