



MAURICIO
CHIROPRACTIC

MAURICIO CHIROPRACTIC APPLICATION FORM

Select One: ☐ Auto Accident ☐ Slip & Fall ☐ Work Related Injury ☐ Private Health ☐ Other:

Date: _____ Home Telephone: _____ Cell Phone: _____

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Email: _____

Date of Birth: _____ Age: _____ Gender: _____ SSN: _____

In case of Emergency we should contact: _____ Phone: _____

Employer: _____ Phone: _____

Occupation: _____ Marital Status: ☐ S ☐ M ☐ W ☐ D

Accident Date: _____ State: _____ Brief Description of the Accident: _____

Where you wearing a seat belt? ☐ Yes ☐ No ☐ N/A

Did you go to the hospital? ☐ Yes ☐ No ☐ N/A If yes, Name of the Hospital: _____

X-Rays Taken? ☐ Yes ☐ No ☐ N/A

Have you lost time from work? ☐ Yes ☐ No Are you still off work? ☐ Yes ☐ No ☐ N/A

If yes, indicate dates lost: From: _____ To: _____

Primary Care Physician: _____ Tel#: _____

Have you been involved in any previous accidents? ☐ Yes ☐ No What Year: _____

If yes explain: _____

Present Complaints (Please be Specific: _____

☐ Mauricio Chiropractic Downtown
205 East Colonial Drive
Orlando, FL 32801

☐ Mauricio Chiropractic Dr, Phillips
7601 Conroy-Windemere Road
#204
Orlando, FL 32835

☐ Mauricio Chiropractic Conway
4747 S. Conway Road Ste A
Orlando, FL 32812

☐ Mauricio Chiropractic Winter Park
1810 Semoran Blvd Ste 104
Winter Park, FL 32792

☐ Mauricio Chiropractic Pine Hills
1050 Pine Hills Road
Orlando, FL 32808

☐ Mauricio Chiropractic E. Colonial
12278 E. Colonial Dr. Ste 700
Orlando, FL 32826

☐ Mauricio Chiropractic South OBT
12720 S. Orange Blossom Trail #20
Orlando, FL 32837

☐ Mauricio Chiropractic Poinciana
860 Towne Center Drive
Kissimmee, FL 34759



Legal Representation: ☐ N/A

Attorney's Name: _____ Tel: _____

Address: _____

Auto Insurance Information: ☐ N/A

Company Name: _____ Adjuster: _____

Policy#: _____ Claim#: _____

Private Health Insurance Information: ☐ N/A

Company Name: _____ Insured: _____

Relation to insured: _____ Group#: _____

Policy#: _____ Phone#: _____

Is there any additional insurance? ☐ Yes ☐ No Please answer the following information:

Company Name: _____ Tel: _____

Insure Name: _____ Relation to the patient: _____

Have you been solicited by an individual concerning this accident? ☐ Yes ☐ No ☐ N/A

If yes, please explain: _____

PLEASE READ AND SIGN

I hereby authorize any physical, hospital, pharmacy, insurance company, employer, or organization to release any and all medical information history, records diagnosis, records or x-rays in your possession concerning the undersigned to Mauricio Chiropractic, LLC, or treating doctor. A photocopy of this authorization shall be valid as the original.

AUTHORIZATION AND ASSIGNMENT: I hereby authorize my insurance company to pay direct to Mauricio Chiropractic, LLC the expenses benefits allowable, and otherwise payable to me under my current insurance policy, as payment toward the total charges for professional services rendered. This payment shall not exceed my indebtedness to the above-mentioned assignee and I have agreed to pay, in a current manner, any balance for said professional services charges over and above this insurance payment.



DOCTORS LIEN: I do hereby authorize the above doctor to furnish you, my attorney, with a full report of his examination diagnosis, treatment, prognosis, etc., of myself in regard to the accident in which I was involved.

I hereby authorize and direct you, my attorney, to pay directly to paid doctor such sums may be due and owing him for medical services rendered me both by reason of this accident and by reason of any other bills that are due his office and to withhold such sums from any settlement, judgment, or verdict as may be necessary to adequately protect said doctor.

And I hereby further give a lien on my case to said doctor against any and all proceeds of any settlement, judgment, or verdict which may be paid to you, my attorney, or myself as a result of the injuries for which I have been treated or injuries in connection therewith.

I fully understand that I am directly and fully responsible to paid doctor for all medical bills submitted by him for services rendered to me and that this agreement is made solely for paid doctor's additional protection and in consideration of his awaiting payment. And I further understand that such payment is not contingent on any settlement, judgment, or verdict by which I may eventually recover paid fee.

Print: _____ Guardian: _____

Signature: _____ Date: _____
