Nadeau Chiropractic Office
3 Health Drive
Augusta, ME 04330

**EMPLOYMENT**

Have you lost any days of work because of this accident?
From_____ To_____
Have your work duties been modified at all since the accident?
Describe: _____

AT THE TIME OF THE WORK INJURY:

- Your Occupation: _____Employed by: _____
- Employer's address: _____
  phone: _____

- Employer's Insurance Company:_____
  Phone:_____

- Did you report the injury to your employer? _____ Yes _____ No
- Did they recommend care at our office? _____ Yes _____ No

**INSURANCE**

Do you have an attorney who has advised you in this case? _____ Yes _____ No
Name: _____
Address: _____
Telephone #: _____

Did you receive a pre-employment physical with this employer? _____ Yes _____ No

I understand and agree that insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company that any amount authorized to be paid directly to this office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Signature: _____