PATIENT INFORMATION

800 Wisconsin Street, Bldg D2, Ste 102,
Mailbox 50, Eau Claire, WI 54703

Phone: 715-833-8533
Fax: 715-839-7902

Your X-Ray Focal Film Distance:

Cervical Lateral Image: ☐ 72″ ☐ 40″ ☐ DMX

Lumbar Images ☐ 40″ ☐ Other (List): ____________

1 Patient Details

First Name: ____________ Last Name: ____________

DOB: ____________ Social Security #: ____________ Sex: ◯ Male ◯ Female

Address: ____________ Home Phone: ____________

City: ____________ State: ____________ Zip: ____________ Work Phone: ____________

2 Referring Physician Details

Name: ____________ Check Applicable: ◯ M.D. ◯ D.O. ◯ D.C.

Clinic Name: ____________ E-Mail: ____________

Address: ____________ Phone: ____________

City: ____________ State: ____________ Zip: ____________ Fax: ____________

Please submit all billing information available, ie: Med Pay, PIP, Liability, Health Insurance and Attorney Information. If your billing software can print a page with all information requested, please submit with these forms.

3 Workers Compensation Details

*Employer Information Required on Workers Compensation Claims

Name of employer: ____________

Pre-Authorization number: ____________

Contact phone number: ____________

4 Insurance Details

Name of Insured: ____________

Relationship to the Patient: ◯ Self ◯ Spouse ◯ Child ◯ Other: ____________

Primary	Secondary
Primary Insurance Company Name: ____________	Secondary Insurance Company Name: ____________
Address: ____________	Address: ____________
City: ____________ State: ______ Zip: ______	City: ____________ State: ______ Zip: ______
Telephone: ____________	Telephone: ____________
Claim # / ID #: ____________	Claim # / ID #: ____________
Group# / Policy #: ____________	Group# / Policy #: ____________
Adjuster / Contact person: ____________	Adjuster / Contact person: ____________

5 Attorney Details

Name: ____________

Address: ____________ Phone: ____________

City: ____________ State: ____________ Zip: ____________ Fax: ____________