

# Lowney Medical Associates

1234 Hyde Park Avenue, Suite 101, Hyde Park, MA. 02136 T: 617-364-2420 F: 617-364-1845

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Today's Date \_\_\_\_\_

Work Related Injury? Y or N Date of Injury \_\_\_\_\_ Job Description \_\_\_\_\_

Auto Injury? Y or N Date of Injury \_\_\_\_\_ Year and type of Auto \_\_\_\_\_

Other type of Injury? \_\_\_\_\_ Date of Injury: \_\_\_\_\_

Were you seen in an Emergency Room? Y or N Date of E.R. visit \_\_\_\_\_

Please describe **in detail** how the injury occurred:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please describe **all areas** of your body that have been injured:  
\_\_\_\_\_  
\_\_\_\_\_

In the past have you ever been examined by a medical provider for similar injuries? Y or N  
If you have had similar injuries in the past please provide the areas of your body and date of previous injuries:  
\_\_\_\_\_  
\_\_\_\_\_

Were you employed prior to the injury? Y or N Name of Employer if yes \_\_\_\_\_

Have you missed and days of work since the injury? Y or N Number of days missed: \_\_\_\_\_  
Have you decreased your work hours or *lightened* your duties since the injury? Y or N

Please briefly describe the **regular** daily activities of your job (heavy lifting, etc.)  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## PATIENT INFORMATION

### Please list auto information for vehicle in which you were first injured:

Name of Auto Insurance: \_\_\_\_\_

Address: \_\_\_\_\_

Phone#: \_\_\_\_\_ Claim#: \_\_\_\_\_

Ins. Adjuster: \_\_\_\_\_ Ext#: \_\_\_\_\_

### Other vehicle information if available:

Name of other vehicle's insurance: \_\_\_\_\_

Address: \_\_\_\_\_

Phone#: \_\_\_\_\_ Claim#: \_\_\_\_\_

Ins. Adjuster: \_\_\_\_\_ Ext#: \_\_\_\_\_

### Attorney Information:

Name: \_\_\_\_\_ Phone# \_\_\_\_\_

### Worker's compensation info if *work* related injury:

Name of Worker's comp Insurance: \_\_\_\_\_

Address: \_\_\_\_\_

Phone#: \_\_\_\_\_ Claim#: \_\_\_\_\_

Ins. Adjuster: \_\_\_\_\_ Ext#: \_\_\_\_\_

I verify that all the information provided is true and correct. I agree to promptly notify Lowney Medical of any change in this information until my account is paid in full. I understand that my insurance will be billed as a courtesy, and that I remain fully responsible for all charges that I incur.

Signature of patient: \_\_\_\_\_ Date: \_\_\_\_\_

# Patient Pain Drawing

Name \_\_\_\_\_ Date \_\_\_\_\_

**Where is your pain now?**

**Mark the areas on your body where you feel the sensations described below, using the appropriate symbol.**

**Mark the areas of radiation. Include all affected areas.**

**To complete the picture, please draw in your face.**

**Aching**

▲ ▲ ▲

**Numbness**

= = = =

**Pins and needles**

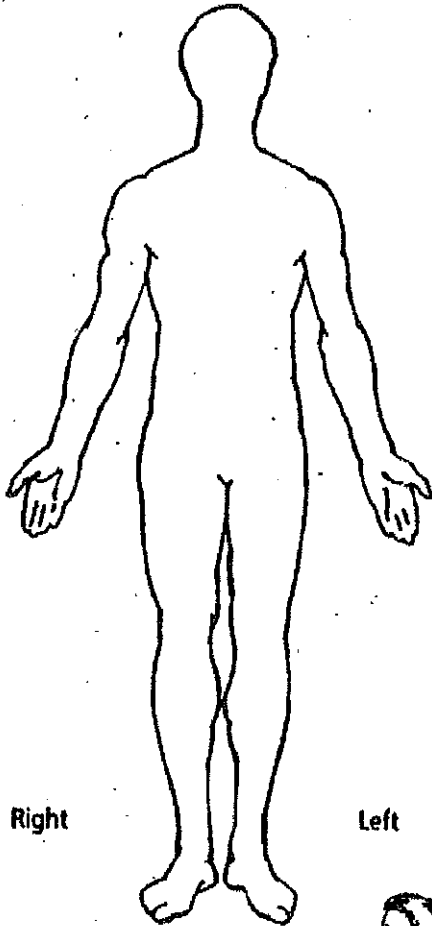
○ ○ ○ ○

**Burning**

X X X

**Stabbing**

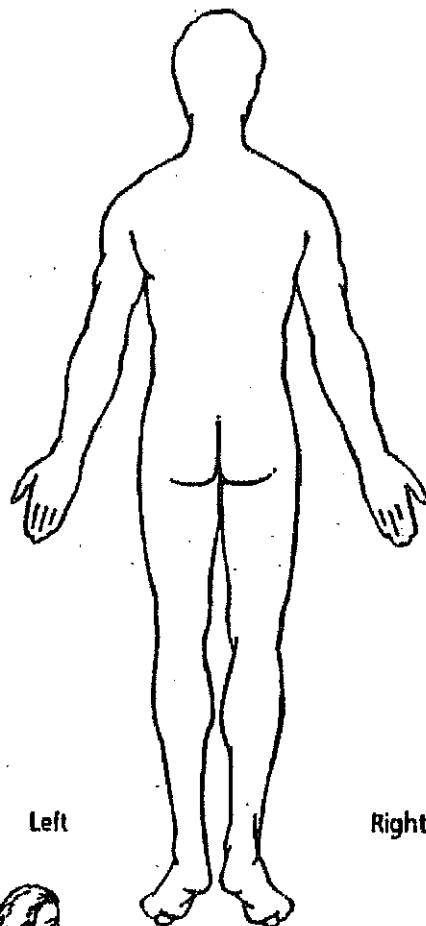
/ / / / /



Right

Left

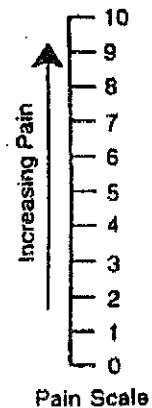
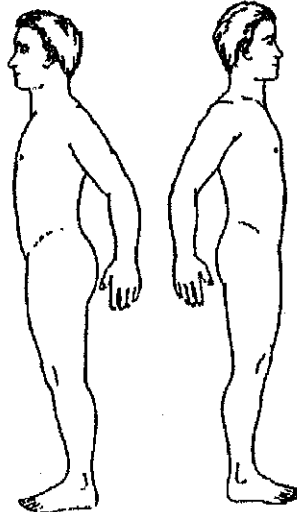
Front



Left

Right

Back



**Lowney Medical Associates**

1234 Hyde Park Avenue, Suite 101

Hyde Park, MA. 02136

T: 617-364-2420 F: 617-364-1845

I hereby authorize my Insurance Co./Lawyer to pay  
directly to Lowney Medical Associates and benefits  
due for charges not paid for by me. Payment of  
this amount, in whole or in part, shall be considered  
the same as if paid by your company directly to me.

SIGNED: \_\_\_\_\_ Date: \_\_\_\_\_

AUTHORIZATION FOR PAYMENT  
FOR MEDICAL FEES  
BY ATTORNEY AND/OR INSURANCE COMPANY

TO:

RE:

I, the undersigned, in consideration of medical services rendered by Lowney Medical Associates, Inc., of Hyde Park, Massachusetts; recognize a lien to said facility on any settlement claim, judgment, or verdict as a result of a related accident or illness and do hereby authorize my attorney AND/OR Ins. Co. to deduct and pay over to LOWNEY MEDICAL ASSOCIATES for said provider such sums as may be due and owing for services rendered to me in connection with my accident of \_\_\_\_\_ and to withhold such sums from any settlement claim judgment, or verdict as may be necessary to protect said server adequately.

Patient: \_\_\_\_\_ Date: \_\_\_\_\_

The undersigned, being the attorney of record for the above patient, does hereby acknowledge receipt of the above lien, and agrees to honor same and to protect adequately the above named provider.

\_\_\_\_\_  
Attorney

\_\_\_\_\_  
Date