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.

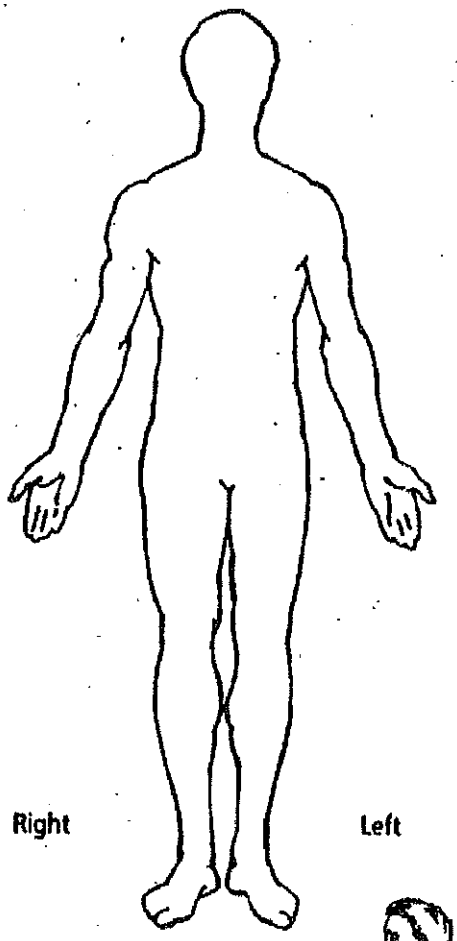
Signature of patient: _____ Date: _____

Patient Pain Drawing

Name _____ Date _____

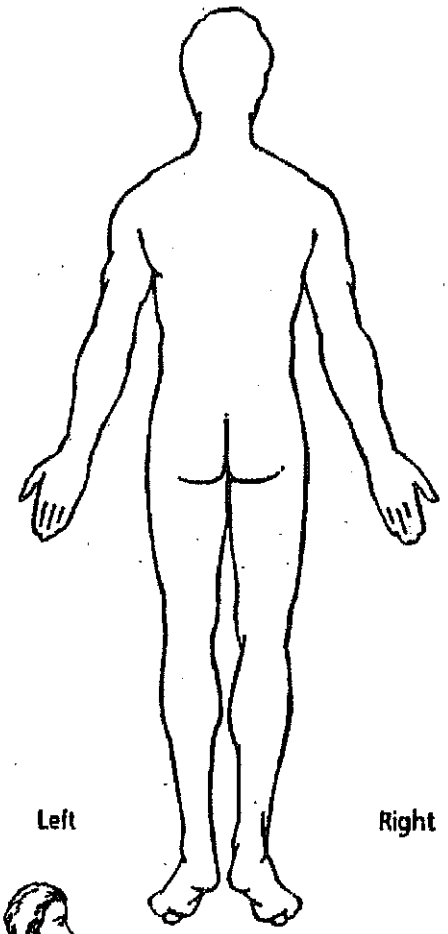
Where is your pain now?
Mark the areas on your body where you feel the sensations desribed below, using the appropriate symbol.
Mark the areas of radiation. Include all affected areas.
To complete the picture, please draw in your face.

Aching	Numbness	Pins and needles	Burning	Stabbing
▲ ▲ ▲	= = = =	○ ○ ○ ○	X X X	/ / / / /



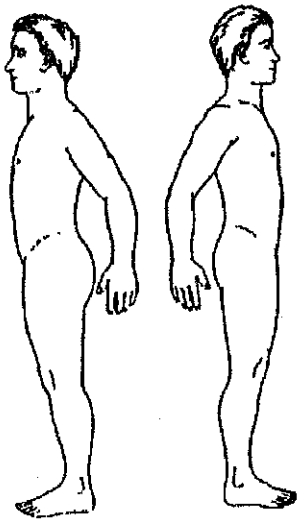
Right Left

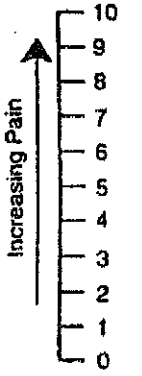
Front



Left Right

Back





Pain Scale

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