

MATHEW A. SNIDER, Jr., D. C.  
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A CHIROPRACTIC CORPORATION  
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FELLOW  
INTERNATIONAL COLLEGE OF CHIROPRACTORS

INDEPENDENT MEDICAL EXAMINER (I.M.E.)  
APPOINTED BY DIVISION OF INDUSTRIAL ACCIDENTS-  
WORKERS' COMPENSATION APPEALS BOARD

**PATIENT INTRODUCTION**

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

Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Telephone: (Home) \_\_\_\_\_ (Work) \_\_\_\_\_

Birthdate: \_\_\_\_\_ Age \_\_\_\_\_ Marital Status (M) (S) (W) (D)

Occupation: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

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

Who referred you to our care? \_\_\_\_\_

What are your principal complaints? \_\_\_\_\_

Have you received previous examination or treatment for this complaint?  
\_\_\_\_\_. If so, from whom? \_\_\_\_\_

Are you under the care of another physician at this time? \_\_\_\_\_

If so, who? \_\_\_\_\_

Nearest relative other than spouse:

Name: \_\_\_\_\_

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

Telephone: \_\_\_\_\_ Relationship: \_\_\_\_\_

Do you have health/accident insurance coverage? \_\_\_\_\_, please read  
the following, which is our policy, concerning the handling of  
insurance claims:

*I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this Chiropractic Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this Chiropractic Office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment.*

Signature **X** \_\_\_\_\_