PATIENT INFORMATION

Today's Date: _____

Patient Contact

Title: Mr./Mrs./Ms./Dr./Rev./Rank_____

Last Name_____ First Name_____ M.I_____

Preferred To Be Called/Nickname_____

Address_____ City_____ State_____ Zip_____

Home Phone_____ Mobile Phone_____

Work Phone_____ E-Mail_____

Patient Personal

Age_____ Date of Birth_____ Gender associated with: Male / Female / Other

Social Security #_____ Drivers License #/State_____

Marital Status: Single / Married / Widowed / Separated / Divorced

Name of Spouse_____ Employer_____ Phone_____

Children (names, ages)_____

Patient Employment

Employer Name_____ Occupation_____

Address_____

Emergency Contact

Name_____ Relationship_____

Home Phone_____ Mobile Phone_____ Work Phone_____

Our office needs to leave messages, return telephone calls, and send office mail to your mailing address as part of our normal practice. Federal/State HIPAA patient privacy laws allow you to restrict doctor/staff communication with you or to contact you through alternative means. Please list telephone numbers that are acceptable for our office to call. Your agreement will allow our office to use your name and the indicated mailing address for sending reminders about scheduled appointments, re-activation letters, sending birthday/holiday cards, office newsletters, or providing information about other health related matters that may be of interest to you, billing statements/questions, status of your account, and other office related matters. This authorization may be revoked by you at any time, by advising our office (Privacy Officer) of this revocation in writing. If you choose not to sign this authorization, this will not have any adverse effect on your treatment, eligibility for benefits, enrollment, or payment.

AUTOMOBILE INSURANCE INFORMATION

Date of Injury: _____

Do you or someone else have insurance coverage for the vehicle you were in?

□ I have □ Someone else has coverage

Indicate the name of the person that the policy is under: _____

How is this person related to you? · Self · Parent · Friend · Other

Name of your Automobile Insurance Carrier:

Address of your Automobile Insurance Carrier:

Claim Adjusters Name/Telephone Number:

Claim Number:

Do you have an Insurance Deductible? · Yes · No Deductible is: $

Do you know your Policy Limits for medical bills? · Yes · No Limit is: $

Have you reported this injury to your insurance carrier? · Yes · No

Do you have an attorney representing you? Yes □ No
If yes, indicate name, address and telephone of your retained attorney:

Attorney Name: _____

Address: _____

Telephone:_____

Our office will provide insurance billing services for you if you so desire as a courtesy. ***Please remember that you are ultimately responsible for any charges incurred in this office. It is your responsibility to pay any deductible amount, co-insurance, and or any other balances not paid by your insurance carrier.***

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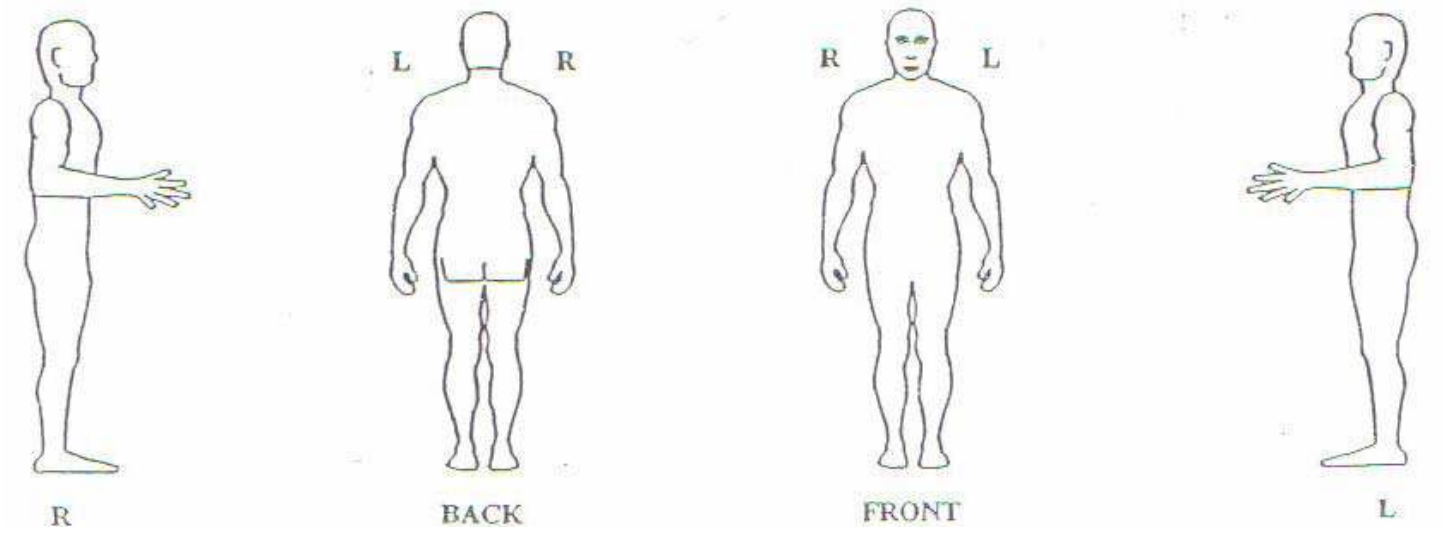
Areas of Complaint

Place "X's" on the areas where you have pain and draw lines to where it radiates:



Did you have any of the above complaints before your injury? Yes / No

Are you experiencing any of the following since your injury? (mark all that apply)

___Headaches	___Blurry vision	___Dizziness/Loss of balance	___Digestive Problems
___Neck Pain	___Rapid heartbeat	___Blood/Lymph disorders	___Shoulder Pain
___Anxiety	___Urinary difficulties	___Indigestion	___Elbow Pain
___Fatigue	___Skin problems	___Breathing Problems	___Wrist/Hand Pain
___Sore throat	___Memory lapses	___Hot/Cold Flashes	___Upper Back Pain
___Knee Pain	___Chest Pain	___Low Back Pain	___Weight Loss/Gain
___Hip Pain	___Mid Back Pain	___Ankle/Foot Pain	

Mechanism of Injury Information

Please write a brief description of how your injury occurred:

_____

_____

Were you stopped? (Yes / No) If no, approximate speed: _____ mph

Was the other vehicle stopped? (Yes / No) If no, approximate speed: _____mph

At impact, was your body straight in your seat? (Yes / No) If no, turned to the (Left / Right)

At impact, were you looking straight ahead?(Yes / No)

If no, was your head turned to the (Left/Right /Up/Down)

Were you aware that you were about to be hit? (Yes / No)

Were you wearing a seatbelt at the time of the accident? (Yes / No)

Did your (chest / head) hit the steering wheel? (Yes / No) Did an airbag deploy? (Yes / No)

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Did your head hit the (Windshield / Side Window)? (Yes / No) Did your shoulder hit the door? (Yes / No)

Did your knees hit the dashboard? (Yes / No) Did the seat break? (Yes / No)

Do you have any (cuts / bruises) from the accident? (Yes / No)

If yes, where?_____

Was your car equipped with headrests? (Yes / No)

If yes, at what height was the top of the headrest? (Base of head / Mid head / Top of head)

Did you lose consciousness? (Yes / No) If yes, how long _____

Treatment Information

Did you go to the Emergency Room? (Yes / No)

If yes, when? _____

Name of the Hospital Emergency Room: _____

List any medications that you were given: _____

List any instructions that you were given: _____

From the following list, circle the treatment(s) that you received at the Emergency Room:

Exam / X-Ray / MRI / CT Scan / Back Brace / Neck Brace / Home Instructions / Other_____

List all the doctors that you have seen as a result of your injuries (other than at the ER):

Date / Doctor Treatment
1._____
2._____
3._____

Do you have any future appointments with any doctor regarding your injuries? (Yes / No)

If yes, when and with whom? _____

Patient Signature_____ Date _____

Guardian Signature (if applicable)_____ Date_____

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