Due West Chiropractic and Rehab

PATIENT INFORMATION & CONDITION FORM

Patient Name: ____ Today's Date: ___/___/___

Birth Date: ___/___/___ Age: ____ Gender: F M

Patient's E-mail address: ___________________________

If you are under 18 years of age, who are your legal parents or guardian?

Father: ____________________________________ Date of Birth: ___/___/___ Phone: (____) ____________

Mother: ____________________________________ Date of Birth: ___/___/___ Phone: (____) ____________

Guardian: __________________________________ Date of Birth: ___/___/___ Phone: (____) ____________

Who do you normally live with? ☐ Mother and Father ☐ Father ☐ Mother ☐ Legal Guardian ☐ None of these

Marital Status: ☐ Married ☐ Separated ☐ Widowed ☐ Single How many children? _________

CURRENT ADDRESS

Street ____

City ____ State ______ Zip ____________________

Phone (_____) ______________

Who should we contact in the event of an emergency? _______________________________ Phone (____) ___________

How did you learn about us? ____

WOMEN ONLY: Are you pregnant or is there any possibility you may be pregnant? ☐ YES ☐ NO ☐ UNCERTAIN

Do you have health insurance? ☐ YES ☐ NO ☐ Not Sure Company: _____________________________________

Full Name of Policy Holder: _________________________ Policy Holder's Date of Birth ___/___/____

Health insurance Id: _____________ Group number: _________________

Attorney name: ________________________ Contact info: ________________________

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I understand and agree that health and accident insurance policies are an arrangement between my insurance company and myself -- not between my insurance company and this office. I agree to pay my estimated patient responsibility and further understand that the estimated responsibility is neither a guarantee of payment by my insurance company, nor necessarily an accurate reflection of my actual responsibility as determined by my insurance company upon processing of my claims. In the event that my insurance company does not pay on my charges at the estimated rate or within a reasonable period of time, upon request of this office I will immediately pay the balance owing on my account unless otherwise agreed to in writing. I understand that an interest charge may appear on all accounts over 90 days. I further understand and agree, that if this office must take any action to collect an outstanding balance on my account, I will be responsible for payment and will reimburse this office for all costs of such collection efforts, including, but not limited to, all court costs and attorney fees.

I authorize this office to release any medical information relating to my treatment to any insurance companies which may be responsible for paying benefits to me, and to any attorney s who may be representing me due to my condition, and to complete any usual and customary reports and forms at no charge to assist in collecting from my insurance companies, attorneys, or other payers.

I have read, understood, and agree to the foregoing. The information which I have provided is true and complete to the best of my knowledge.

Patient's Signature: ____ Date: ___/___/____

DUE WEST CHIROPRACTRIC AND REHAB **Patient Questionnaire – Auto-Accident**

Patient Name: ____ Today's Date: ___/___/___

Basic Information about the Accident:

Date Accident Occurred: ___/___/___ Time of Day when Accident Occurred or Started: ___:_____ AM / PM

Describe how the Accident took place: ____

____

____

____

Describe the condition or symptoms caused by the Accident: ____

____

____

____

Auto-Accident Specific Information:

Were you the: ☐ Driver ☐ Passenger ☐ Pedestrian

Automobile you were in: Year _________ Make ________________ Model _______________

Damage to your car: ☐ Front ☐ Rear ☐ Pedestrian ☐ Driver Side ☐ Passenger Side ☐ Bumper ☐ Fender

Damage Amount Estimate: $_____________ : ☐ Minor ☐ Major ☐ Totaled

Other Automobile: Year _________ Make ________________ Model _______________

Damage to other car: ☐ Front ☐ Rear ☐ Pedestrian ☐ Driver Side ☐ Passenger Side ☐ Bumper ☐ Fender

☐ Minor ☐ Major ☐ Totaled

Where did the accident happen? Street Names: __________________________________ City/State _____________________________

Was it? ☐ Controlled Intersection ☐ Uncontrolled ☐ Not Intersection

Was there a traffic light? ☐ None ☐ Green ☐ Red ☐ Turn Arrow ☐ Stop Sign

Were you: ☐ Slowly Moving ☐ Moving ☐ Stopped

Weather Conditions: ☐ Sunny ☐ Rainy ☐ Cloudy

Street Surface: ☐ Dry ☐ Wet ☐ Slick ☐ Icy ☐ Pavement ☐ Other ______________________

Type of Impact: ☐ Rear end ☐ Front ☐ Side Impact ☐ Roll Over

Brakes on Impact: ☐ Locked Tight ☐ Loosely Applied ☐ Foot not on brake

How far did your car move? ☐ Did not move ☐ Moved 1-5 ft ☐ Moved 6-10 ft ☐ Moved over 10 ft

Where were you seated in the vehicle: __________________________________ Wearing Seat belt? ☐ Yes ☐ No

Shoulder harness: ☐ Yes ☐ No Headrest: ☐ Yes ☐ No Headrest Position: ☐ Up ☐ Down

Is the car equipped with airbags? ☐ Yes ☐ No Did they deploy? ☐ Yes ☐ No

Did you see the impact coming? ☐ Yes ☐ No Did you brace yourself for impact? ☐ Yes ☐ No

On impact, your head was looking: ☐ Ahead ☐ Behind ☐ Up ☐ Down ☐ To the Right ☐ To the Left

On impact were you: ☐ Thrown forward ☐ Thrown backwards ☐ Thrown sideways ☐ Other ______________________

Did your body hit anything inside the car? ☐ Yes ☐ No Body Part: _________________________

What did it hit? _______________________________

Head trauma? ☐ Yes ☐ No Loss of Consciousness? ☐ Yes ☐ No For how long? ______________________

Do you remember the accident happening? ☐ Yes ☐ No

Hospital? ☐ Yes ☐ No Name of hospital: ____________________________ How long there? ____________________________

Taken by ambulance? ☐ Yes ☐ No

X-rays taken? ☐ Yes ☐ No X-ray areas: ☐ Neck ☐ Mid-back ☐ Low-back ☐ Other X-rays _________________________

Medication Given? ☐ Yes ☐ No RX: ____

Other instruction: ___________________________________ Follow-up: ____

Additional Information Related to the Condition:

Describe your pain: ☐ Burning ☐ Sharp ☐ Dull ☐ Ache

What caused it? ____

What aggravates it? ____

What relieves it? ____

Has the Patient ever had the same or similar condition or symptoms previous to this most recent occurrence? ☐ Yes ☐ No

When? ___/___/___

Describe: ____

____

____

____

Please indicated any other healthcare providers who the Patient has seen for the condition or symptoms:

Name	Type of Licensure	Date of Last Visit
________________	_________________________	___/___/___
________________	_________________________	___/___/___

Please check any of the following symptoms you are now experiencing:

☐ Headache	☐ Dizziness	☐ Light Bothers Eyes	☐ Diarrhea	☐ Head seems too heavy	☐ Neck Pain
☐ Loss of Memory	☐ Clumsiness	☐ Feet Cold	☐ Neck Stiff	☐ Tingling in arms/hands	☐ Ears Ring
☐ Hands Cold	☐ Sleeping Problems	☐ Tingling in legs/feet	☐ Face Flushed	☐ Nausea	☐ Back Pain
☐ Numbness in arms/hands	☐ Buzzing in Ears	☐ Constipation	☐ Nervousness	☐ Numbness in legs/feet	☐ Loss of Balance
☐ Cold Sweats	☐ Tension	☐ Shortness of Breath	☐ Fainting	☐ Fever	☐ Fatigue
☐ Irritability	☐ Loss of Smell	☐ Chest pain/rib pain	☐ Pain in arms/hands	☐ Pain in legs/feet	☐ Jaw pain
☐ Loss of strength - arms	☐ Burning muscle pain	☐ Loss of strength - legs	☐ Difficulty swallowing	☐ Sharp/shooting pain	

Other ______________________________

Have you experienced changes to:

☐ Eyes (sight)	☐ Ears (hearing)	☐ Nose (smell)	☐ Mouth (taste)	☐ Bladder
☐ Bowels	☐ Sleep	☐ Emotion	☐ Appetite	

Please Explain: ____

Have you missed work or school due to your injuries? ☐ Yes ☐ No

Do you smoke? ☐ Yes ☐ No

Do you drink alcohol? ☐ Yes ☐ No

Medical History:

Have you ever been in our office before? ☐ Yes ☐ No

List any previous accidents (automobile, on the job injuries, slips, falls, sports, etc.) and provide the accident date:

1) ____ ___/___/___

2) ____ ___/___/___

3) ____ ___/___/___

Surgeries/Hospitalizations: ____

Allergies (please list all): ____

Do you now or have you ever had:

☐ Heart Disease	☐ Diabetes	☐ Cancer	☐ Stroke	☐ High Blood Pressure	☐ Thyroid Problems
☐ Tuberculosis	☐ Prostate Disorder	☐ Kidney Problems	☐ Asthma	☐ Ulcer	☐ Seizure Disorder

Other: ______________________________

Due West Chiropractic & Rehab, LLC
Authorizations & Releases/Financial Policy/Lien for Services
ACCIDENT PATIENTS

Consent for Treatment
____ I, the undersigned, hereby authorize the Doctors of Due West Chiropractic & Rehab and whomever they may designate as their assistant(s), to preform evaluations, diagnostic tests, and to administer treatment as is necessary. I also certify that no guarantee or assurance has been made as to the results that may occur as a result of this treatment.

Certification, Authorization and Release in Accordance with HIPPA
_____ I authorize the release of any medical information necessary to process my insurance claim(s) and also certify that all insurance and accident information given by me to Due West Chiropractic & Rehab is correct and complete. I understand that my medical information, relating to this personal injury case, may be shared to manage and expedite my medical treatment. I authorize my treating physician(s) and Due West Chiropractic & Rehab, to secure, release and disclose medical treatment information only with companies, individuals, and any necessary parties involved in my case.

Request for Payment of Benefits to Provider or Care
______ I hereby authorize my insurance company/insurance administrator to pay by check and for it to be mailed directly to Due West Chiropractic & Rehab, any benefits allowable, and otherwise payable to me under my current policy, as payment toward the total charges for professional services rendered.

Payment Policy
_____ Due West Chiropractic & Rehab expects to be paid by the first available means whether by health insurance, your Auto Medical Payments, or settlement of your cases. It is the policy of Due West, to file all available applicable insurance on an accidental injury patient including: Health Insurance: Proof of insurance must be provided in order for us to file claims with your insurance company. Please understand that benefits through health insurance policies differ. Insurance companies pay according to your individual policy limits. Benefits are between you and your insurance carrier. Any discrepancies with your benefit coverage must be handled by you and your insurance provider. Any portion of your medical bills that are not covered by your insurance will be included in your statement sent to your attorney and paid once your case settles. Auto Insurance: Due West does not file against the third party insurance. If there is Med Pay on your policy or on the policy of the car you were a passenger in, Due West will submit to that carrier. If there are medical benefits available there may be a maximum allowable amount coverage, which may not cover all charges in full. Any portion of your medical bills that are not covered by your health insurance or Med Pay coverage will be included in your statement sent to your attorney and paid once your case settles.

Health Insurance Company: ________________________________ Member ID: _____________________________

Auto Insurance Company: _________________________________ Member ID: _____________________________

Date of Accident: ____ Claim Number: ___________________________

Adjuster's Name: ____ Contact Number: _________________________

Consent for Treatment of Minor
____ I, the undersigned, hereby authorize the doctors of Due West Chiropractic & Rehab and whomever they may designate as their assistant(s), to perform evaluations, diagnostic tests and to administer treatment as is necessary to my child (Child's Name) _________________________of which I am the legal guardian.

I understand, agree to and will abide by all of the above. I will cooperate in processing this accident claim. I fully understand and acknowledge that I am responsible for all medical charges incurred by me for services provided by Due West Chiropractic & Rehab.

____________________________ ____/____/______ ___________________________ ____/____/______

Printed Name of Patient Date of Birth Signature of Patient Today's Date

____________________________ ____/____/______

Due West Chiropractic Witness Today's Date