ACCIDENT INFORMATION

Please PRINT clearly.

Today's Date: ________________________

PATIENT INFORMATION

Name: (Last, First, MI) ____ **Preferred Name**: ______________

ACCIDENT INFORMATION -- *Please use back of this page if needed.*

Date of accident: _________________ Time of Accident: _____________ Number of people in accident vehicle: ___________

Location/street of Accident: ____

Were you the: ☐ Driver ☐ Front Passenger ☐ Rear Passenger -- Behind Driver / Middle / Behind Passenger / 2nd Row / 3rd Row

Name of Driver, *if not you* ____________________________ Name of Driver of other Vehicle: ______________________________

Make/Model of Vehicle you were in: ____

Is vehicle equipped with airbags? ☐ Yes ☐ No Did airbags inflate? ☐ Yes ☐ No Were you wearing a seatbelt? ☐ Yes ☐ No

Where did the impact come from? ☐ Front ☐ Rear ☐ Driver side ☐ Passenger Side

In relation to the base of your skull, where was the headrest? ☐ Above ☐ Below ☐ At the base

In what direction were you headed? ☐ North ☐ South ☐ East ☐ West

In what direction was the other vehicle headed? ☐ North ☐ South ☐ East ☐ West

During impact were you facing: ☐ Forward ☐ Backward ☐ Right ☐ Left

Did any part of your body strike anything in the vehicle? ☐ Yes ☐ No (Describe): ____________________________________

____

Were you rendered unconscious? ☐ Yes ☐ No If yes, for how long? ___________

What was the approximate speed of your vehicle? ________ The other vehicle? ___________

Were you ☐ Aware ☐ Surprised by the impact? What did your vehicle impact? ☐ Another vehicle ☐ Other: _______________

Please list the name of the other victims in the accident, if any: ____

____

In your own words please describe the accident in detail: ____

____

____

____

INSURANCE INFORMATION

Your Auto Ins: ______________________ Policy #________________ Claim# _________________ Phone# _______________

Address: ____

Other's Auto Ins: ____________________ Policy #________________ Claim# _________________ Phone# _______________

Address: ____

CONFIDENTIAL PATIENT HEALTH HISTORY

Please PRINT clearly.

Today's Date: ______________________

PATIENT INFORMATION

Name: (Last, First, MI) ____ **Preferred Name:** ____________

Address: ________________________________ **City:** ________________ **State:** ______ **Zip:** ________

Home: ________________ **Mobile:** ____________ **Mobile Carrier:** ___________ **Work:** ________________

Email: ________________________________ **Gender:** M / F **Marital Status:** Married / Single / Other

Best way to reach you: home / cell / work / email Date of Birth: ________________ Age: ________________

Preferred patient reminders: email / text Occupation: ________________ Employer: ______________

Who may we thank for referring you to our office? ____

CMS requires providers to report both race and ethnicity

Ethnicity: Not Hispanic or Latino / Hispanic or Latino / Other / Decline to Answer **Preferred Language:** ______________

Race: Asian / Black or African American / American Indian or Alaskan Native / White (Caucasian) / Native Hawaiian or Pacific Islander
Other / Decline to Answer

Smoking Status: Every Day / Some Days / Former / Never

EMERGENCY CONTACT INFORMATION

Full Name: ____________________________ **Name of Previous Chiropractor:** ______________________

Home: ____________ **Mobile:** ______________ **Date of Last Chiropractic Adjustment:** __________________

Relationship: Child / Parent / Spouse / Other: ______ **Primary Care Physician:** ________________________

Doctor's Phone: ________________________________

FINANCIAL INFORMATION -- *Please allow our staff to photocopy your insurance card.*

Insurance Self Pay (Cash) Personal Injury/Auto Other (please explain) ____________________

PRIMARY INSURANCE

Name: ________________________________

Relation to Insured: Self / Spouse / Parent / Child / Other

Other than Self:
Insured's Name: ____________________ **Gender:** M / F

Address: ________________________________

City: ______________ **State:** ________ **Zip:** ______

Phone: ______________ **Date of Birth:** ____________

SECONDARY INSURANCE

Name: ________________________________

Relation to Insured: Self / Spouse / Parent / Child / Other

Other than Self:
Insured's Name: ____________________ **Gender:** M / F

Address: ________________________________

City: ______________ **State:** ________ **Zip:** ______

Phone: ______________ **Date of Birth:** ____________

List all medications, Dosage and Frequency (i.e. 5 mg once a day, etc.) *Did you bring a list? Can we make a copy?*

____

____

____

CURRENT CONDITION INFORMATION *PLEASE ANSWER ALL QUESTIONS*

Describe Major Complaint for seeking care today: ____________________
Onset of Symptoms: ____________ Describe how it began: ____________________

Grade Intensity/Severity of Complaint: None (0) Mild (1-2) Mild-Moderate (2-4) Moderate (4-6) Moderate-Severe (6-8) Severe (8-10)

Is the complaint/pain: Sharp / Stabbing / Burning / Achy / Dull / Stiff & Sore / Numb / Other: ____________

How frequent is the complaint present? Come & Go / Constant

Does this complaint radiate/shoot to any areas of your body? No / Yes *(Describe)* ____________________

Head - Base of Skull / Forehead / Sides-Temple R / L / Both *Leg* - Hip / Thigh-Knee / Foot-Toes R / L / Both

Arm - Across Shoulder / Elbow / Hand-Fingers R / L / Both *Other Area:* ____________________

Does anything make the complaint better? Ice / Heat / Rest / Movement / Stretching / OTC / Other: ____________

Does anything make the complaint worse? Sit / Stand / Walk / Lying / Sleep / Overuse / Other: ____________

How does this condition affect your daily activities? *(Describe)* ____________________

Have you received any prior treatment for this condition?

DC / MD / PT / Massage / ER / Other: ____________ Where? ____________

Surgery? *(Describe)* ____________________

Medications? OTC / Prescriptions *(Describe)* ____________________

Diagnostic testing? X-rays / MRI / CT / Other: ____________ When and Where? ____________

❑ Acupuncture ❑ Massage ❑ Other: ____________________

Describe any Secondary Complaints: ____________________

HEALTH HISTORY SINCE LAST VISIT *(PLEASE USE REVERSE SIDE OF PAGE IF NEEDED)*

MEDICATION:

Allergies to Medications: *(List and reactions)* ____________

Vitamins & Supplements: *(List all and frequency)* ____________

RECENT HEALTH HISTORY:

Surgeries – Date, Type and Reason: ____________

Major Injuries/Traumas:

Major Hospitalizations including year:

SOCIAL AND OCCUPATIONAL HISTORY:

Lifestyle: *(Your Hobbies, Rec. Activities, Exercise, Diet, Health Goals)*

Habits:

Cigarettes – (#/day) ____________
Alcohol – (amount/day) ____________
Coffee/Tea – (cups/day) ____________
Rec. Drugs: (list) ____________

Patient/Guardian Signature: ____________________ **Date:** ____________

MEDICAL INFORMATION

BEFORE THE ACCIDENT:

Have you had complaints in the involved area? ☐ Yes ☐ No

Were they present at the time of the accident? ☐ Yes ☐ No

Describe: ______________________________

Were you able to work without restrictions before the accident? ☐ Yes ☐ No

AT THE TIME OF THE ACCIDENT:

Did you feel pain immediately after the accident? ☐ Yes ☐ No ☐ Later that Day ☐ Next Day ☐ When? ____________

Did you go to a hospital or seen any other doctor? ☐ Yes ☐ No When did you go? ☐ Immediately ☐ Next Day ☐ Other_____

How did you get there? ☐ Ambulance ☐ Private Transportation Was medication prescribed? ☐ Yes ☐ No

Describe the treatment you received: ______________________________

Name of hospital and/or attending doctor:______________________________

Was he/she a : ☐ DDS ☐ MD ☐ DC ☐ DO Were any x-rays taken? ☐ Yes ☐ No

SINCE THE ACCIDENT:

Are your symptoms: ☐ getting better ☐ getting worse ☐ staying the same

Have you been able to work since this injury? ☐ Yes ☐ No

Are your work activities restricted as a result of this injury? ☐ Yes ☐ No

LEGAL INFORMATION

Did the police come to the scene of the accident? ☐ Yes ☐ No Was a police report filed? ☐ Yes ☐ No

Were there any witnesses? ☐ Yes ☐ No Was a traffic violation issued? ☐ Yes ☐ No To whom? ____________

Have you retained an attorney? ☐ Yes ☐ No If yes, whom? ____________Phone:____________

Patient/Guardian Signature:______________________________ **Date:** ____________

Consents

Consent to Bill/Collect Insurance: I consent, if I am using a third party for payment of my services (health insurance, auto accident insurance, worker's compensation insurance, Parent/Guardian, etc), to allow Young Chiropractic (Dr. Timothy Young) to submit all necessary information needed to receive payment for the services I received to these third parties. I further consent to accept assignment of payments from my insurance company to be paid directly to the office or doctor.

Patient/Guardian (circle)

Name ______ Patient/Guardian Signature ______ Date

Consent to Examination and Treatment: I give the doctors and staff of Young Chiropractic permission to perform all examinations, x-rays, and treatment deemed necessary by the doctor. I understand that some of these procedures may be performed by either the staff or the doctor.

Patient/Guardian (circle)

Name ______ Patient/Guardian Signature ______ Date

Consent to Retrieve Medical Records: I give the doctors and staff of Young Chiropractic permission to obtain any and all medical records from other providers, offices or hospitals which may assist with my care.

Patient/Guardian (circle)

Name ______ Patient/Guardian Signature ______ Date

HIPPA: A copy of the full Health Information Privacy Policy for our office can be requested at the front desk. In brief, it states that we will not give any information about you except as consented above. The only people we give information to are your parents/guardians if you are a minor or whomever is responsible for your bill (i.e. insurance company, third party, or attorney if you have one).

Patient/Guardian (circle)

Name ______ Patient/Guardian Signature ______ Date

Clinical Summary Report (CCR): I understand that a clinical summary report is created after each visit for the purpose of EHR and is available for my review. At this time, I am asking Young Chiropractic to save these electronically for me and not print them out after each visit. I understand that, upon request, these reports are available to be printed or emailed to me for review.

Patient/Guardian (circle)

Name ______ Patient/Guardian Signature ______ Date

Pregnancy Waiver (Women Only): By my signature below, I am stating that to the best of my knowledge, I am not pregnant nor is pregnancy suspected at this time.

Patient/Guardian (circle)

Name ______ Patient/Guardian Signature ______ Date

PERSONAL INJURY COVERAGE

PATIENT NAME: ______________________________________

DEFENDANTS NAME (other driver): ________________________

DEFENDANTS
(other driver)
INSURANCE Co.: ______________________________________

DEFENDANTS
INSURANCE CO.
ADDRESS: ______________________________________

____

INSURANCE PHONE: __________________________________

DATE OF ACCIDENT: __________________________________

CLAIM NUMBER: ____________________________________

POLICY NUMBER: ____________________________________

HAS ACCIDENT BEEN REPORTED? YES ____ NO _____

INSURANCE ADJUSTER'S NAME: __________________________

ESTIMATED DAMAGE TO YOUR AUTO. $____________________

DO YOU HAVE MED-PAY ON YOUR INSURANCE COVERAGE? YES ___ NO___

WOULD LIKE US TO FILE ON YOUR MED-PAY? YES _____ NO____

YOUR INSURANCE COMPANY NAME AND ADDRESS:

____

____

ATTORNEY INFORMATION

ATTORNEYS NAME: ____

NAME OF LAW FIRM: ____