PLEASE PROVIDE US WITH THE FOLLOWING PERSONAL AND OTHER PERTINENT INFORMATION REQUESTED

Today's Date: _____

Name: _____ Nickname Preferred: _____

Date of Birth: _____ ❑ Male ❑ Female

Mailing Address: _____ Social Security # _____

City/State/ZIP: _____ Home Phone: ( ) _____

Occupation: _____ Work Phone: ( ) _____

Employer: _____

Employer's Address: _____

City/State/ZIP: _____

Were you referred by: ❑ Yourself ❑ Friend ❑ Insurance Carrier ❑ Primary Physician ❑ Other Physician

FINANCIAL	YOUR AUTO INSURANCE CARRIER	YOUR MAJOR MEDICAL CARRIER
NAME		
ADDRESS		
CITY/ST/ZIP		
POLICY #		
INSURED NAME		

OTHER FINANCIAL	OTHER DRIVERS INSURANCE CARRIER	YOUR ATTORNEY
NAME		
ADDRESS		
CITY/ST/ZIP		
POLICY #		Phone:
INSURED NAME		Fax:

Please describe the accident in your own words: _____

I the undersigned hereby authorize the staff to perform such services as deemed necessary by the physician to diagnose and treat my condition(s). Further I authorize assignment of my insurance rights and benefits directly to this provider and also authorize the release of such information as is needed to process insurance claims. I understand that I am responsible for all charges which may include legal fee, collection fees or other expenses incurred by the provider in collecting my account. I hereby order all parties to accept a copy of this release and assignment in lieu of the original. This shall remain in effect until revoked by me in writing.

Signature _____ Date _____

Date of Accident: Time of Accident: Was A Police Report Filed? ❑ No ❑ Yes

Involving: ❑ Car ❑ Taxi ❑ Van ❑ Truck ❑ Motorcycle ❑ Bus ❑ Other

Were you: ❑ Driver ❑ Passenger [ ] Front [ ] Back ❑ Pedestrian ❑ Riding a Bicycle

Were you struck from: ❑ Front ❑ Behind ❑ Left ❑ Right ❑ Left Oblique ❑ Right Oblique

Did you strike: ❑ Window ❑ Door ❑ Dash ❑ Steering Wheel Were you wearing a seat belt? ❑ No ❑ Yes

Did you hit your head? ❑ No ❑ Yes Did you lose consciousness? ❑ No ❑ Yes How long?

Were you taken to the hospital? ❑ No ❑ Yes [ ] By ambulance [ ] By relative [ ] Drove myself

Name of hospital and address:

Were you (please check all that apply):

❑ Kept overnight ❑ Admitted for_____days

❑ X-rayed ❑ Treated cuts/bruises

❑ Treated for fractures ❑ Examined and released

❑ Examined and released with medications

❑ Advised to follow up with my own physician on next day

Have you ever been in an accident before? ❑ No ❑ Yes

When / Where?

What problems are you having today?

ON THE FIGURES AT RIGHT, PLEASE MARK YOUR AREA(S) OF PAIN OR DISCOMFORT.

+++ Burning /// Stabbing

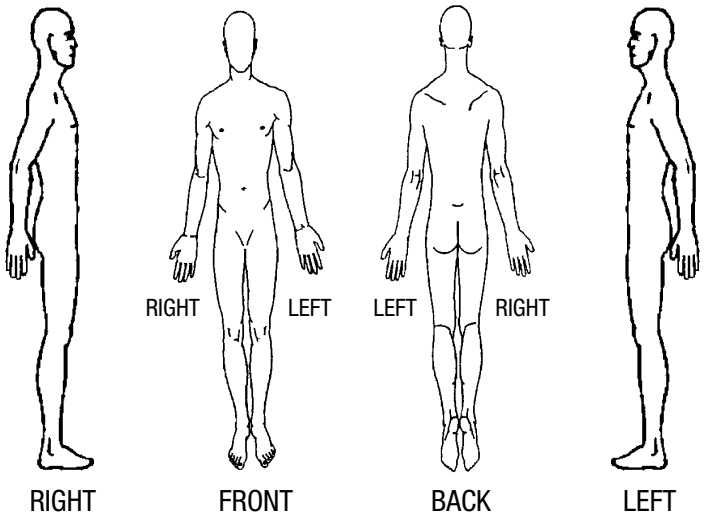
••• Pins & Needles XXX No Feeling

Circle the areas (if more than one) of pain and tell us on a scale of 1 to 10, with 1 being light pain, to 10 being very severe, how severe is your pain in each area most of the time.

AREA 1 pain is (1–10) _____

AREA 2 pain is (1–10) _____

AREA 3 pain is (1–10) _____



Which words describes your pain MOST of the time?

❑ Constant ❑ Tingling

❑ On and off ❑ Burning

❑ Occasional ❑ Throbbing

❑ Only at night ❑ Deep, stabbing

❑ Only on exertion ❑ Deep, achy

❑ Dull ache ❑ Sharp recurring pain

How would you describe your current mobility?

❑ Self-mobile ❑ Need walker

❑ Need cane ❑ Need wheelchair

Which best describes your current employment?

❑ Working ❑ Full time ❑ Part time

❑ Unemployed

❑ On sick leave

❑ On temporary disability

❑ On permanent disability

❑ Retired

If on temporary or permanent disability or sick leave, last full day of work was:_____

PATIENT	**ID#**	**DATE**