General Information (Please complete to the best of your ability. Do not hesitate to ask questions).

Name: ____ **Date:** __________________

Home Address: ____

City___________________________ **State:** __________ **Zip Code:**_____________

Cell Phone:____________________________________

Home Telephone:_________________ **Work Telephone:** ___________________

Email:____

Date of Birth: ___________________ **Age:** ________ **Gender:** ☐ Male ☐ Female

Social Security Number: _________________________________

Marital Status:____

How did you hear about us? _______________________________

Emergency Contact: _____________________________________

Primary Care Physician: ____

Primary Care Physician Telephone Number:__________________________________

Date of Motor Vehicle Accident: ____

What hand do you write with? ☐ Right ☐ Left

Were you wearing a seatbelt at the time of the accident? ☐ Yes ☐ No

Did an airbag deploy? ☐ Yes ☐ No ☐ Not Applicable

Position in the vehicle at the time of the accident:
☐ Driver ☐ Passenger Front ☐ Rear Drivers Side ☐ Rear Passenger Side

Accident Information

Type of Vehicle you were in: ____

Year: ________________ **Make**:__________________ **Model**:________________

Type of other Vehicle(s) involved (if applicable): ______________________________

____

My car was: **(Please check all that apply)**	**Estimated Damage to Vehicle:**	**If you would like briefly sketch the accident (OPTIONAL):**
☐ Hit from behind ☐ Hit on the passengers side ☐ Hit on the drivers side ☐ Hit in the front ☐ I hit into another vehicle or obstruction. If checked, Please explain___________________ ___________________ ☐ None of the above. If checked, Please explain_____________ ___________________	**$**____________ **Police Report** ☐ Yes ☐ No	

Body Positioning / Injury Information **(Please answer to the best of your recollection)**

Were you able to brace for the impending impact?

☐ Yes
☐ No
☐ Uncertain

When the motor vehicle accident occurred did your head hit anything?
(i.e. steering wheel, mirror, windshield)

☐ Yes
☐ No
☐ Uncertain

If yes, what did you impact?

☐ Side window
☐ Rear view mirror
☐ Airbag
☐ Dashboard
☐ Other ____

Were your hands on the steering wheel at the moment of impact?	**Did your hands impact the dashboard?**
☐ Yes ☐ No ☐ Uncertain If yes, please explain ______________________________ ______________________________	☐ Yes ☐ No ☐ Uncertain If yes, please explain ______________________________ ______________________________

Did your chest or any other body part hit the steering wheel?	**Was your shoulder forcefully restrained by the seatbelt?**
☐ Yes ☐ No ☐ Uncertain If yes, please explain ____________________ ____________________	☐ Yes ☐ No ☐ Uncertain If yes, please explain ____________________ ____________________
Did your knees hit the dashboard?	**Were your feet jammed or twisted on a pedal of the floorboard?**
☐ Yes ☐ No ☐ Uncertain If yes, please explain ____________________ ____________________	☐ Yes ☐ No ☐ Uncertain If yes, please explain ____________________ ____________________
Did any other body part hit anything inside the car?	
☐ Yes ☐ No ☐ Uncertain If yes, please explain ____________________ ____________________	

History of Treatment to Date

How would you best describe your condition immediately after your accident

☐ Shaken up but functional ☐ Dazed and confused
☐ Circumstances Vague ☐ Loss of consciousness

Briefly describe your symptoms immediately after your injury (if any).

____

____

Initial Treatment

☐ Yes ☐ No Were you taken to the emergency Room

If yes, How were you transported? ____________________

If yes, What treatment did you receive? ____________________

If yes, What instructions were given you when you left the emergency room? ____________________

____

☐ Yes ☐ No If you were initially taken to the emergency, were you admitted to the a hospital?

If yes, please describe: ____________________

____

☐ Yes ☐ No Did you have any of your present symptoms prior to this motor vehicle accident?

If yes, please describe____________________

____

Treatment of Injuries to Date

☐ **Yes** ☐ **No** **Have your symptoms worsened compared to how they were immediately after your accident?**

☐ **Yes** ☐ **No** **Have you seen your family physician since your injury?**

☐ **Yes** ☐ **No** **Has your family physician prescribed any medication to you for your injuries? If yes, please list:** ____________________

____

☐ **Yes** ☐ **No** **Have you been referred for any diagnostic tests due to your Injuries?**

If yes, check below and indicate where you had the test done on the line next to the test.

☐ **X-rays** ____________________

☐ **CAT Scan** ____________________

☐ **EMG** ____________________

☐ **MRI** ____________________

☐ **Other** ____________________

☐ **Yes** ☐ **No** **Have you been to physical therapy? If yes:**

A. When did you start? ____________________

B. Where did you go? ____________________

C. How often did you go? ____________________

D. How long did you go for? ____________________

☐ **Yes** ☐ **No** **Have you been seen by any specialists (i.e. Physical Medicine, Rehabilitative specialists, Surgeons or Chiropractors)? If yes, Please list.**

1. ____________________

2. ____________________

3. ____________________

4. ____________________

5. ____________________

About Your Injuries

Important – We strive to learn as much as possible about each and every injury that occurred to you as a result of this motor vehicle accident so that we may establish a comprehensive and efficient treatment plan.

Please complete the left side of the page (below) to let us know where you are injured, but you are not required to go into detail. The right side of the page will be utilized by your physician and your injuries will be covered in detail.

Patient Overview of Symptoms

As a result of your injury please check any of the following activities that you find to be difficult and / or painful.

1._____ Headaches

2._____ Dizziness

3._____ Blurred Vision

4._____ Jaw Pain

5._____ Face / Nose / Neck Pain

6._____ Neck Pain

Physician Detailed Review / Symptoms

(This side office use only- please do not write in box)

____ **1. Headaches: (Description)** ________________________
VAS_______/10
☐ Concussion ☐ Photophobia ☐ Nausea
☐ Cognitive Impairment ☐ Affect Blunted

____**2. Balance:** ____
☐ Vertigo ☐ Generalized

____**3. Vision:**____
☐ Blurred ☐ Halo Effect ☐ Diploplia

____**4. TMJ:** ____
☐ Auscultory click ☐ Deviation
☐ Pain with Chewing ☐ Tooth Fractures

____**5. Face:** ____
☐ Air bag burn
☐ Septal Defect(if yes, 2° to MUA) ☐ yes ☐ No
☐ Laceration ☐ Sinus Cavity

____**6. Cervical Spine:** _________________________________
VAS_________
☐ LUE Radicular Features
☐ RUE Radicular Features

About Your Injuries

Patient Overview of Symptoms

As a result of your injury please check any of the following activities that you find to be difficult and / or painful.

7._____Left Shoulder Pain

8._____ Right Shoulder Pain

9._____ Left Elbow Pain

10._____ Right Elbow Pain

11._____ Right Wrist Pain

12._____ Left Wrist Pain

Physician Detailed Review / Symptoms

(This side office use only- please do not write in box)

____7. Left Shoulder: ______________________________

☐ Seat Belt Caught(driver) ☐ Osseus Pain
☐ Rotator Cuff / bursael / labram / impingement

____8. Right Shoulder:______________________________

☐ Seat Belt Caught(driver) ☐ Osseus Pain
☐ Rotator Cuff / bursael / labram / impingement

____9. Left Elbow: ______________________________

VAS______/10
☐ Contusion ☐ Jammed

____ 10. Right Elbow: ______________________________

VAS______/10
☐ Contusion ☐ Jammed

____ 11. Right Wrist/Hand :__________________________

VAS______/10
☐ N/T into digits ☐ Awaken w / Numbness
☐ Severe focalosseus pain
☐ Thumb tenderness

____ 12. Left Wrist/Hand:

____

VAS______/10
☐ N/T into digits ☐ Awaken w / Numbness
☐ Severe focalosseus pain
☐ Thumb tenderness

About Your Injuries

Patient Overview of Symptoms	Physician Detailed Review / Symptoms
As a result of your injury please check any of the following activities that you find to be difficult and / or painful.	(This side office use only- please do not write in box)
13._____ Rib Cage Pain	**____ 13. Ribcage / Sternal Pain:____________________** VAS______/10 ☐ Left Side ☐ Right Side ☐ Bilateral ☐ Intercostal ☐ Osseus / Cartilagenous ☐ Sternal
14._____ Mid Back Pain	**____ 14. Mid Back Pain:________________________** VAS______/10
15._____ Low Back Pain (with or without leg pain)	**____ 15. Low Back Pain:________________________** VAS______/10 ☐ LLE Radicular Features ☐ RLE Radicular Features
16._____ Left Knee Pain	**____ 16. Left Knee: ____________________________** VAS______/10 ☐ Clicking ☐ Locking
17._____ Right Knee Pain	**____ 17. Right Knee:___________________________** VAS______/10 ☐ Clicking ☐ Locking
18._____ Left Foot/Ankle Pain	**____ 18. Left Foot/Ankle: ________________________** VAS______/10
19._____ Right Foot/Ankle Pain	**____ 19. Right Foot/Ankle: _______________________** VAS______/10
20._____ Lacerations__________________	**____ 20. Lacerations: ____________________________** ____
21._____ Bruises _____________________	**____ 21. Bruises:** ______________________________________ ____

About Your Injuries

Patient Overview of Symptoms	Physician Detailed Review / Symptoms
22._____ Other Injuries	(This side office use only- please do not write in box) ____ 22. Other Injuries:

About Your Injuries

Secondary Symptoms

Patient Overview of Symptoms

As a result of your injury please check any of the following activities that you find to be difficult and / or painful. Additionally I have experienced:

A.______ Difficulty Sleeping

B.______ Nervousness

C.______ Depression

D.______ Difficulty Concentrating

E.______ Difficulty Breathing

F.______ Visual Changes

G.______ Irritation

H.______ Difficulty tasting / smelling

I. ______ Please list any social or recreational activities that you once enjoyed prior to your injuries but now find it either difficult or impossible (i.e. playing with children, exercising, golf, traveling or general social activities).

1. ______________________________

2. ______________________________

3. ______________________________

4. ______________________________

5. ______________________________

Physician Detailed Review / Symptoms

(This side office use only- please do not write in box)

Description: ____________________________________

Description: ____________________________________

Description: ____________________________________

Description: ____________________________________

Description: ____________________________________

Description: ____________________________________

Description: ____________________________________

Description: ____________________________________

About Your Injuries

Physical Limitations

Patient Overview of Symptoms

As a result of your injury please check any of the following activities that you find to be difficult and / or painful.

___ **Lifting**

___ **Bending**

___ **Twisting**

___ **Turning**

___ **Reaching**

___ **Sitting**

___ **Standing**

___ **Walking**

___ **Pushing**

___ **Pulling**

___ **Gripping**

___ **Sexual Activity**

___ **Performing every day activities of daily such as dressing, housework, driving, shaving, etc**

Physician Detailed Review / Symptoms

(This side office use only- please do not write in box)

Notes: ____
____
____
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____
____
____
____
____

___ Note for restrictions / limitations requires

___ Note for disability required

Past Injury History (WORK OR AUTO)

VERY IMPORTANT!!!! Have you ever been involved in a Work Injury or Auto Injury? Y or N

Personal Medical History

Have you ever been diagnosed with any of the following:

- ☐ Yes ☐ No Allergies
- ☐ Yes ☐ No Anemia
- ☐ Yes ☐ No Asthma
- ☐ Yes ☐ No Back Pain
- ☐ Yes ☐ No Depression / Anxiety
- ☐ Yes ☐ No Stomach / Intestinal Problems
- ☐ Yes ☐ No Blood Disorder
- ☐ Yes ☐ No Headaches
- ☐ Yes ☐ No Hepatitis
- ☐ Yes ☐ No Liver Disease
- ☐ Yes ☐ No Cancer
- ☐ Yes ☐ No Heart Disease
- ☐ Yes ☐ No Stroke
- ☐ Yes ☐ No Hypoglycemia
- ☐ Yes ☐ No HIV
- ☐ Yes ☐ No Thyroid Disease
- ☐ Yes ☐ No Gastro intestinal
- ☐ Yes ☐ No Reflux Disease
- ☐ Yes ☐ No Hiatal Hernia
- ☐ Yes ☐ No Gall Bladder Disease

Surgical History

Please list all of the surgeries you have had (if any) with the approximate date

- ______________________________
- ______________________________
- ______________________________
- ______________________________
- ______________________________
- ______________________________
- ______________________________
- ______________________________

Medications

List all Medications prescribed for the injury
(Please list dosage, frequency and prescribing doctor.)

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________
5. ______________________________
6. ______________________________

List all Medications that you were taking prior to this injury

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________
5. ______________________________
6. ______________________________

Allergies

List all know allergies **(including medications)**

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________
5. ______________________________
6. ______________________________

Family History

Do you have a family history (this would be mother, father, grandparents or siblings) of any of the following:

☐ **Yes**	☐ **No**	**Cancer**	☐ **Yes**	☐ **No**	**Heart Disease**
☐ **Yes**	☐ **No**	**Diabetes**	☐ **Yes**	☐ **No**	**Strokes**
☐ **Yes**	☐ **No**	**Liver Disease**	☐ **Yes**	☐ **No**	**Blood Disorders**
☐ **Yes**	☐ **No**	**Lung Disease**	☐ **Yes**	☐ **No**	**Thyroid Disease**

☐ **Other:**____

If you answered yes to any of the above questions indicate who in you family had the disorder.
____
____

Social History

1. Marital Status: ________________________ Number of Children:_________________

2. Education Status (check all that apply):
   - ❒ Grade School
   - ❒ High School
   - ❒ GED
   - ❒ Some College
   - ❒ Associates Degree
   - ❒ Specialty Degree (PTA, Dental Hygienist, Chiropractic Tech, MRI Tech)
   - ❒ 4 Year Degree
   - ❒ Graduate Degree
   - ❒ Doctorate (PhD, MD, etc)

Job Description and Work History

Employer: ____

Job Title: ____

❒ **Yes** ❒ **No** Does your job require lifting?

If yes, what is the maximum amount you are required to lift? ___________________

Place an ✓ next to all that apply to your job requirements:

❒ Lifting (max weight)	❒ Pushing
❒ Bending	❒ Pulling
❒ Twisting	❒ Reaching
❒ Gripping	❒ Overhead Activity
❒ Repetitive Use of arms	❒ Repetitive use of legs

Others: ____

What is the average number of hours you are required to sit per day? _________________

What is the average number of hours you are required to stand per day? _______________

What is the average number of hours you are required to work per week? ______________

Alcohol and Tobacco History

❒ **Yes** ❒ **No** Do you smoke tobacco? (if yes how much do you smoke) _______ packs per week.
❒ **Yes** ❒ **No** Do you chew tobacco?
(If yes, On Rare Occasions _______ Moderate ________ Heavy _________).

❒ **Yes** ❒ **No** Do you consume alcohol?

a. Never __________
b. Very Rarely __________
c. Lightly________ (average 1 drink or less per day)
d. Moderately _______ (average 2-3 drinks per day)
e. Heavily _______ (average 4 or more drinks per day)

Scale: 1 Drink = 12 oz. of Beer
5 oz. of Wine
1 oz. of Hard Liquor

❒ **Yes** ❒ **No** Have you ever been addicted to alcohol, prescription drugs, or street drugs?

Patient request for Patient Records

Date: ________________________

To: ______________________________________

Patient Name: ____

I hereby authorize the release of my Medical Records and request that they be transferred to:

Physicians Plus Spine &Rehab Center
1106 Pulaski Highway
Bear, DE 19701

I understand and agree to allow Physicians Plus to use my Patient Health Information for the purposes of treatment, payment, healthcare operations, and coordination of care. I understand that my medical records are privileged and confidential information and that my records will be utilized by this office strictly within the parameters of my legal rights concerning said records.

Patient Signature:______________________________________

Social Security :____

Insurance Information

Name: ____ Date: _______________

Name of the Insurance carrier responsible for payment: ___________________________________

Insurance Claim Number: ______________________________

Name of Insurance Company's Claim Adjustor that has been assigned to handle the bodily injury portion of your claim: ___________________________________

Adjustors Telephone Number: _______________________________ Ext: ____________________

Important - for your protection

[ ] Yes [ ] No	I have completed and returned all of the required insurance forms to initiate payment of my medical bills.
[ ] Yes [ ] No	I am fully aware that it is my responsibility to complete all forms as mandated by my insurance company in order to have my medical expenses paid.
[ ] Yes [ ] No	I am aware that if I have not completed all paperwork (in a timely manner) my medical expenses will not be covered and it is possible for my insurance carrier to deny payment of my entire claim.
Note:	We're fully aware that dealing with insurance companies after an injury can be potentially confusing. We are here at your service to provide support to the very best of our ability. Please never hesitate to ask for assistance.

Private Insurance Information

The name of your private insurance company: ____

ID Number: _______________________________

Please Note:	This information is important for your protection in the unlikely event of the denial of your claim.
Important:	Please allow us to make a copy of your insurance card for our own records.

Attorney Information (If applicable)

[ ] Yes [ ] No Do you have an attorney to assist you? If yes, please complete below.

Attorney: ____

Law Firm: ____

Paralegal: ____

Address: ____

____

Telephone: ____

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the Physicians Plus. I authorize physician to release all information necessary to communicate with personal physicians and other healthcare providers and payors and to secure the payment of benefits. In the unanticipated event that the expenses for my treatment are not covered by my Insurance Carrier (or Private Insurance) I am responsible for payment of professional services.

I understand and agree to allow Physicians Plus Center to use my Patient Health Information for the purposes of treatment, payment, healthcare operations, and coordination of care. I understand that my medical records are privileged and confidential information and that my records will be utilized by this office strictly within the parameters of my legal rights concerning said records.

I am aware that there is a more detailed account of all policies and procedures concerning the privacy of my Patient Health Information. We encourage you to read the HIPAA NOTICE that is available to you desk for you to read in its entirety at the front, before signing this notice. If there is anyone you do not want to receive your medical records, please inform our office.

______________________________	____________________
Patient Signature	**Date**
______________________________	____________________
Guardian's Signature Authorizing Care	**Date**

PATIENT: ____

ID#: ____

GROUP#: _______________________________________

I hereby instruct and direct that ____ Insurance Company to pay by check made out and mailed to:

Physicians Plus Spine & Rehab Center
1106 Pulaski Hwy
Bear, DE 19701

If my current policy prohibits direct payment to the doctor, then I hereby also instruct you to make out a check to me and mail it as follows:

C/O Physicians Plus Spine & Rehab Center
1106 Pulaski Hwy
Bear, DE 19701

The professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. This is a direct assignment of my rights and benefits under this policy. This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay in a current manner, nay balance of said professional service charges over and above this insurance payment.

A photocopy of this assignment shall be considered as effective and valued as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

__________________________________ ________/_______/_______
Signature of Patient Date

__________________________________ ________________________
Signature of Policyholder Witness

I hereby authorize Physicians Plus to file a formal written complaint with the Insurance Commissioner when necessary.

____
Signature of Patient

LIMITED POWER OF ATTORNEY TO ENDORSE CHECKS

KNOW ALL MEN BY THESE PRESENTS: That the undersigned has made, constituted, and appointed

Physicians Plus Spine & Rehab Center

And any of its duly authorized agents and employees as and to be the undersigned's true and lawful Attorney for and in the undersigned's name, place, and stead to endorse any and all checks, drafts, or money orders which are made payable to the undersigned. Said checks, drafts, or money orders are to pay for chiropractic services or the like, which have been or are to be performed at the request or with the knowledge and approval of the undersigned and/or the maker of the check, draft, or money order.

The undersigned by these presents does thus give and grant this limited power of attorney to the above named office or doctor, including the full power and authority to do and perform as the undersigned might or could do if personally present as far as the endorsing and cashing of said checks are concerned.

The undersigned does hereby ratify and confirm any and all actions taken by the said office or doctor in accordance with this special power of attorney and which the said office or doctor shall do or cause to be done by virtue of these presents.

IN WITNESS THEREOF the undersigned have set their hands, this ______ day of _________________, 20________.

Patient's full name:____

Signature of patient:____

Witness to patient's signature:____

Notice of Doctor's Lien

Patient: ___________________________________

Date of Accident: ____________________________

I do hereby authorize Physicians Plus Spine & Rehab Center to furnish you, my attorney, with a full report of his examination, diagnosis, treatment, prognosis, etc., of myself in regard to the accident in which I was recently involved.

I hereby authorized and direct you, my attorney, to pay directly to said doctor such sums as may be due and owing him for medical service rendered me both by reason of this accident and by reason of any other bills that are due to his office and to withhold such sums for any settlement, judgment or verdict as may be necessary to adequately protect and fully compensate said doctor. And I hereby further give a Lien on my case to said doctor against any and all proceeds of my settlement, judgment or verdict which may be paid to you, my attorney, or myself, as the result of the injuries for which I have been treated were injuries in connection therewith.

I fully understand that I am directly and fully responsible to said doctor for all medical bills submitted by him for service rendered me and that this agreement is made solely for said doctors additional protection and in consideration of his awaiting payment. And I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee.

I agree to promptly notify said doctor of any change or edition of attorney(s) used by me in connection with this accident, and I instruct my attorney to do the same and promptly deliver a copy of this lien to any such substituted or added attorney(s).

Please acknowledge this letter by signing below and returning to the doctor's office. I have been advised that if my attorney does not wish to cooperate in protecting the doctor's interest, the doctor will not await payment but may declare the entire balance due and payable.

Dated: ________________________ Patient's Signature: _________________________

The undersigned being attorney of record for the above patient does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgment, or verdict, as may be necessary to adequately protect and fully compensate said doctor above-named. Attorney further agrees that in the event this lien is litigated that the prevailing party will be awarded attorney fees and costs.

Dated: ________________________ Attorney's Signature: ________________________

Medical Information Release Form
(HIPAA Release Form)

Name: ___________________________________ Date of Birth: _____/____/_____

Release of Information

[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released
to:
[ ] Spouse____
[ ] Child(ren)______________________________________
[ ] Other____
[ ] Information is not to be released to anyone.

This ***Release of Information*** will remain in effect until terminated by me in writing.

<u>Messages</u>

Please call [ ] my home [ ] my work [ ] my cell
Number:__________________
If unable to reach me:
[ ] you may leave a detailed message
[ ] please leave a message asking me to return your call
[ ] ____
The best time to reach me is (*day*)___________________ between (*time*)_________

Signed: __________________________ Date:____/____/_____

Witness:_________________________ Date: ___/____/______

PREGNANCY WAIVER

I hereby acknowledge that Physicians Plus has informed me prior to being x-rayed of the advisability of risk and the probable consequences of receiving x-rays during pregnancy. I have stated on my own that I was not pregnant at the time and do hereby release and hold harmless from any legal action or responsibility caused by the use of this procedure.

____

Printed Name of Patient

____

Signature of Patient/Authorized Representative of Patient

____

Witness

Date: ____________________________________