

New Patient Registration and Accident Questionnaire ①

Name: _____ Age: _____ Date of birth: _____ Date: _____
 LAST FIRST MIDDLE

Address: _____ Social Security #: _____ Male Female

City, State, Zip: _____ Marital Status: M S W D # of Children _____

Home Phone (_____) _____ Work Phone (_____) _____

Cell Phone (_____) _____ Email address: _____

Employer: _____ Spouse's Name: _____

Occupation: _____ Spouse's Employer: _____

In case of emergency, notify _____ **Relationship:** _____ **Phone (_____)** _____

Current Symptoms: 1. _____ 2. _____ 3. _____ 4. _____

5. _____ 6. _____ 7. _____ 8. _____

When did your symptoms begin? _____

In general what makes your symptoms better? _____

In general what makes your symptoms worse? _____

In general how would you describe your pain? (ache, burn, dull, sharp, throbbing): _____

Are your symptoms local or do they travel to another area? (If they travel, to where?) _____

Are symptoms; Constant >76% Frequent 51-75% Occasional 26-50% Intermittent <25% of your waking hours

Were there any symptoms which you had after the crash/accident that have now resolved? (please list)

Please list all medications and dosage: **Frequency** **For What Illness?**

List any allergies to medications, foods or other: _____

Are you pregnant? Yes No First day of last menstrual cycle: _____

Do you smoke? Yes No; How much? _____ Do you drink alcohol? Yes No; How much? _____

Please list all serious illness and serious accidents: **Month and Year** **City, State**

Patient's Name: _____ Date: _____

DO YOU HAVE A HISTORY OF ANY OF THE FOLLOWING DISEASES?:

Tuberculosis <input type="checkbox"/> Yes	Lung Disease <input type="checkbox"/> Yes	Gout <input type="checkbox"/> Yes	Diabetes <input type="checkbox"/> Yes
Kidney Disease <input type="checkbox"/> Yes	Stomach/Ulcer <input type="checkbox"/> Yes	Heart Disease <input type="checkbox"/> Yes	Hepatitis <input type="checkbox"/> Yes
Sciatica <input type="checkbox"/> Yes	Blood Pressure <input type="checkbox"/> Yes	Transfusion <input type="checkbox"/> Yes	Polio / MS <input type="checkbox"/> Yes
Colon Disease <input type="checkbox"/> Yes	Stroke <input type="checkbox"/> Yes	Cancer <input type="checkbox"/> Yes	Bleeding <input type="checkbox"/> Yes
Paralysis <input type="checkbox"/> Yes	Seizures <input type="checkbox"/> Yes	Arthritis <input type="checkbox"/> Yes	Asthma <input type="checkbox"/> Yes
Anemia <input type="checkbox"/> Yes	Thyroid Disease <input type="checkbox"/> Yes	Drug Dependence <input type="checkbox"/> Yes	AIDS <input type="checkbox"/> Yes

PLEASE PROVIDE US WITH THE APPROPRIATE INSURANCE INFORMATION:

1) YOUR AUTOMOBILE INSURANCE CARRIER: _____

Address: _____ Telephone: (____) _____ Insured: _____

Claim #: _____ Policy #: _____

Claim Representative: _____

Telephone: (____) _____ Fax: (____) _____

Med-Pay Benefits: _____ Uninsured (UM) Benefits: _____ Underinsured (UIM) Benefits: _____

Have you signed a selection waiver of benefits? Yes No Unsure

Are you a full time Student? Yes No Do you reside with a relative? Yes No

2) YOUR HEALTH INSURANCE COMPANY: _____

Address: _____ Insured: _____

Date of Birth: _____ Policy #: _____ SS#: _____

Telephone: (____) _____ Fax: (____) _____

3) ADVERSE OR THIRD PARTY AUTOMOBILE INSURANCE CARRIER: _____

Address: _____ Claims Rep: _____

Claim #: _____ Policy #: _____ Insured: _____

Telephone: (____) _____ Fax: (____) _____

4) ATTORNEY: _____ Legal Assistant: _____

Address: _____

Telephone: (____) _____ Fax: (____) _____

HIPAA Compliance

Our office is required by law to maintain the HIPAA Notice of Privacy Practices. This notice explains our legal duties and privacy practices with respect to your protected health information. Signature below acknowledges that I have read this Notice of our Privacy Practices. A copy will be provided to me upon request.

Patient Signature: _____ Date: _____

Witness: _____ Date: _____

Staff Initials: _____