Personal Injury Questionnaire

Patient Info

Name _____ Phone (home) _____(work) _____

Address _____ City _____ State _____ Zip _____

Date of Birth _____ Age _____ Social Security # _____

Employer Address _____ City _____ State _____ Zip _____

Your Car Insurance Company _____ Phone _____

Policy # _____ Claim # _____ Adjuster_____

Name on policy if other than self _____ Relation _____

Their Address _____ Their Phone # _____

Med Pay: Y N If yes, the amount allowed _____ Amount used _____

Third Party (other vehicle involved)

Name _____ Their Insurance _____

Insurance Co. Phone _____ Fax _____ Claim # _____

Address of Their Insurance Co. _____

Adjuster for Their Insurance Co. _____

Attorney Information (if you have one)

Name _____ Phone _____ Fax _____

Address _____ City _____ State _____ Zip _____

Contact _____

Information about the accident

Date of accident _____ Time _____ Police Report? Y N

Were you a: Driver Passenger Were you struck from: Behind Front Left Right

Speed of your car _____ mph Speed of their car _____ mph Were the police notified? Y N

In your own words, describe the accident:

_____

_____

_____

Did you have any physical complaints before the accident? Y N

If yes, what complaints?

_____

_____

_____

Describe how you felt

During the accident: _____

Immediately after: _____

Later that day: _____

The next day: _____

What are your PRESENT symptoms and complaints?

_____

_____

_____

Do you have any congenital (from birth) factors which relate to this problem? If so, describe:

_____

_____

_____

Have you ever been involved in an accident before? If yes, please describe, including date(s) and type(s) of accidents as well as injuries received:

_____

_____

_____

Have you received any medical / chiropractic treatment after this accident? Y N

If yes, what type of treatment did you receive and where? _____

_____

Have you had x-rays taken since the accident? Y N

Since this injury, how would you describe the progression? Better Worse Same

Check symptoms that you have noticed since the accident:

☐ Headaches ☐ Dizziness ☐ Blurred vision ☐ Nausea/vomiting ☐ Loss of balance

☐ Loss of smell/taste ☐ Ringing/buzzing in the ears ☐ Sensitivity to light ☐ Loss of memory

☐ Neck pain ☐ Neck stiffness ☐ Pain at night ☐ Problems sleeping ☐ Irritability

☐ Pain into the arms ☐ Numbness/tingling into the arms ☐ Numbness/tingling into the hands

☐ Mid-back pain ☐ Rib pain ☐ Pain with deep breath ☐ Pain with coughing/sneezing

☐ Shortness of breath ☐ Chest pains ☐ Lower back pain ☐ Change in bowel/bladder habits

☐ Pain into the legs ☐ Weakness of leg muscles ☐ Numbness/tingling into the legs

☐ Other _____

Have you missed work due to this accident? Y N

If yes, please give the dates: _____

Have you noticed any activity restrictions as a result of your injuries in this accident? Y N

If yes, please describe your activity restrictions: _____

Patient Signature _____ Date _____

OasisMD
Lifestyle Healthcare

Patient Name:_____ **DOB:** _____ **Patient ID#:**_____

Patient Financial Liability Statement

I, the patient or legal representative for the patient, understand that I am personally financially responsible for charges incurred for services rendered by Oasis MD, if any of the following apply:

1) My health plan required prior authorization or referral by my Primary Care physician forbore receiving services at Oasis MD and I have not obtained the authorization or referral as needed to comply with insurance plan policy or I have received services more than what was approved; **and/or**

2) My health plan determines that the services rendered at the Oasis MD are not medically necessary or are not a covered benefit under my health plan policy; **and/or**

3) My health plan coverage has lapsed or expired at the time I received services at Oasis MD; **and/or**

4) Oasis MD is not a contracted provider for my health plan and I have agreed to pay CASH and/or higher copays/deductible/co-insurance for all services rendered.

I also understand that I am responsible for all deductibles, co-payments and co-insurance under my Health Plan.

If my account must be referred to an attorney for collection, I agree to pay reasonable attorney's fees and collection expenses.

I am the patient or am authorized to sign this agreement. I have received a copy, and understand and accept its terms.

_____ _____

Patient /Legal Representative Signature **Relationship**

_____ _____

Witness **Date**

Travis C. Ehlers, DC, CCSP

Informed Consent To

Chiropractic Treatment

I hereby request and consent to the performance of Chiropractic adjustments and any other chiropractic procedures, including examinations tests, diagnostics x-rays, physical therapy or any procedures used by Dr. Ehlers or staff in this office on me, (or on the patient named below for which I am legally responsible) which are recommended by Dr. Ehlers or staff at Oasis MD.

I understand that, as with all health care procedures, there are certain complications which may arise during an adjustment. Those complications include, but are not limited to: fractures, disc injuries, dislocations, muscle strain, Horner's Syndrome, diaphragmatic paralysis, cervical myelopathy and cost vertebral strains and separations. Some types of manipulation to the neck have been associated with injuries to the arteries of the neck, leading to, or contributing to serious complications including stroke do not expect the doctor to be able to anticipate all the risks and complications and I wish to rely on the doctor to exercise his or her judgment during the course of the procedure which the doctor feels at the time, based upon the facts then know, are in my best interest.

I understand that my doctor will be unable to perform any services without my acknowledgment of the above and without my consent as indicated by signing this form. If I have any questions about the above or the information in this form will address these with the doctor prior to the initial treatment.

I have read or have read to me the above explanation of the Chiropractic adjustment and related treatment. By signing below, I state that I have weighted the risks involved in undergoing treatment and have myself decided that it is in my best interest to undergo the Chiropractic treatment and have myself decided that is in my best interest to undergo the Chiropractic treatment recommended. Having being informed of the risks hereby give my consent to treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment.

_____ _____

Printed Name of Patient Date

_____ _____

Signature of Patient/Guardian/Representative Date

OASISMD
Lifestyle Healthcare
Tel. (858) 571-0606 Fax: (858) 571-1933
499 N. El Camino Real Ste C-200 Encinitas, CA 92024
Tel. (760) 635-7800 Fax: (760) 635-7801

Patient Name: _____ DOB: _____ Account #: _____

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

In accordance with the Federal Government Privacy Rules implemented through the Healthcare Portability Act of 1996 (HIPAA), I, _____, hereby authorize ***OASIS MD*** to release any and all medical records concerning my care to any physician, hospital or other health care professional providing care to me at any time.

I also authorize ***OASIS MD*** to discuss my condition, treatment or diagnosis to the following family members, individuals and/or caregivers:

_____ _____
(Name) Relationship

_____ _____
(Name) Relationship

Home Phone: _____ May we leave a detailed message: YES/NO
Cell Phone: _____ May we leave a detailed message: YES/NO
E-Mail: _____ May we send you a detailed message: YES/NO

_____ _____
PATIENT SIGNATURE DATE

ACKNOWLEDGEMENT OF PRIVACY PRACTICES NOTICE RECEIPT

I, _____, understand that under the Healthcare Portability Act of 1996 (*HIPAA*) I have certain rights to privacy regarding my Protected Health Information (*PHI*). I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in my treatment directly and indirectly
- Obtain payment from Third-Party Payers
- Conduct normal healthcare operations such as quality assessments and physician certifications

I have received, read and understand your Notice Of Privacy Practices containing a more complete description of the uses and disclosures of my *PHI*. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Private Practices.

I understand that I may request in writing how my *PHI* is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

_____ _____
PATIENT SIGNATURE DATE

OFFICE USE ONLY

I attempted to obtain the patient's signature to confirm receipt of the Notice of Privacy Practices but was unable to do so as documented below:

Date:	Initials:	Reason: