AUTOMOBILE ACCIDENT QUESTIONNAIRE

- PLEASE ANSWER ALL QUESTIONS COMPLETELY-

PATIENT INFORMATION: **DATE:** _____

Name: _____ **SS #:** _____

Sex: Male Female **E-mail address:** _____

Marital Status: S M D W **Primary Language:** _____

Race: Caucasian Black Asian Other **Ethnicity:** Hispanic Non-Hispanic

Birth date: _____-_____-_____ **Age:** _____ **Are you a minor?** _____

Address: _____
Street Address Town State Zip code

Home Phone: ( )_____ **Cell Phone:** ( )_____
please indicate which number is best to reach you at

EMPLOYMENT INFORMATION:

Employer /Business Name: _____

Phone #: ( )_____ **EXT:** _____

Address: _____

Job Title: _____

INSURANCE INFORMATION: - Of the vehicle in which you were injured

Insurance Company: _____

Policy #.: _____

Claim #.: _____

Name of the policyholder: _____

Name and phone number of your insurance adjustor:
_____

ATTORNEY INFORMATION:
Name: _____ **Phone #:** ( )_____

Address: _____

How were you referred to our office? : _____

VEHICLE ACCIDENT REPORT

Name _____

1. Date of Accident ____ / ____ / ____ 2. Time of Accident ____:____ (AM / PM)
3. Were you: **A)** Driver **B)** Passenger (Front) **C)** Passenger (Rear) **D)** Pedestrian
4. Were you wearing seatbelts? ___ Yes ___ No
5. Type of vehicle: **A)** Auto **B)** Truck **C)** Van **D)** Motorcycle **E)** Motor home **F)** Bicycle
6. How accident occurred: **A)** Struck by another vehicle **B)** Struck another vehicle **C)** Struck a stationary object **D)** Other
7. Where was your vehicle hit? **A)** Front **B)** Rear **C)** Rt. Side **D)** Lft. Side **E)** Rt. Front **F)** Lft. Front **G)** Rt. Rear **H)** Lft. Rear
8. Where was other vehicle hit? **A)** Front **B)** Rear **C)** Rt. Side **D)** Lft. Side **E)** Rt. Front **F)** Lft. Front **G)** Rt. Rear **H)** Lft. Rear
9. Your approximate speed _____ MPH 10) Other vehicle approximate speed _____ MPH
11. What occurred at the moment of impact? (Circle as many as apply)
    A) Tensed body for impact **B)** Neck whipped forward & back **C)** Spine torqued and twisted **D)** Thrown over seat
    E) Thrown from vehicle **F)** Pinned in vehicle **G)** Thrown from side to side **H)** Cut and bruised
12. Did you strike your: (Circle as many as apply)

A. Head Against the: 1) Dashboard 2) Windshield 3) Steering Wheel 4) Rt. Door 5) Lft. Door 6) Seat Frame 7) Unknown Object
B. Shoulder Lft / Rt Against the: 1) Dashboard 2) Windshield 3) Steering Wheel 4) Rt. Door 5) Lft. Door 6) Seat Frame 7) Unknown Object
C. Arm Lft / Rt Against the: 1) Dashboard 2) Windshield 3) Steering Wheel 4) Rt. Door 5) Lft. Door 6) Seat Frame 7) Unknown Object
D. Elbow Lft / Rt Against the: 1) Dashboard 2) Windshield 3) Steering Wheel 4) Rt. Door 5) Lft. Door 6) Seat Frame 7) Unknown Object
E. Wrist Lft / Rt Against the: 1) Dashboard 2) Windshield 3) Steering Wheel 4) Rt. Door 5) Lft. Door 6) Seat Frame 7) Unknown Object
F. Hip Lft / Rt Against the: 1) Dashboard 2) Windshield 3) Steering Wheel 4) Rt. Door 5) Lft. Door 6) Seat Frame 7) Unknown Object
G. Knee Lft / Rt Against the: 1) Dashboard 2) Windshield 3) Steering Wheel 4) Rt. Door 5) Lft. Door 6) Seat Frame 7) Unknown Object
H. Ankle Lft / Rt Against the: 1) Dashboard 2) Windshield 3) Steering Wheel 4) Rt. Door 5) Lft. Door 6) Seat Frame 7) Unknown Object

13. Were you rendered unconscious? (Y / N) 14. Did you receive medical attention at the scene of the accident? (Y / N)
15. Where did you go immediately following the accident? **A)** Hospital **B)** Home **C)** Personal Doctor **D)** To this office **E)** Resumed Activities
16. Were you: (Circle as many as apply) **A)** Shaken **B)** Disoriented

Did you have any physical complaints before the accident? (Y/N) If "YES" please describe _____

_____

_____

In your own words, please describe the accident _____

_____

_____

_____

How did you feel immediately after the accident? _____

_____

_____

_____

Important: This form may be used in the determination of insurance benefits and/or litigation for compensation. It is imperative that this form be filled out completely to protect your rights of compensation.

Past History:

1. Have you ever injured this area before? _____ If yes, when? _____
2. If injured before, did you lose time from work? _____
3. If you lost time from work with injuries prior to this injury, give name of doctor or doctors consulted

   _____
4. Have you been involved in any previous accidents of any kind (personal injury, automobile accident or workers' compensation? ____ If yes, please explain dates and details _____

   _____

   _____
5. Have you been treated previously by a chiropractor? ____ If yes, please explain _____

   _____

Present Information/Disability:

1. Have you returned to work? ____ If yes, date returned to work _____
2. Job description _____
3. Do you have to favor any part of your body in your work? ____ If yes, please explain

   _____
4. Are your work activities restricted as a result of this accident? ____ If yes, please explain

   _____
5. Since this injury, are your symptoms: improving ____, getting worse ____ or the same ____ ? Please explain _____
6. Do any other diseases or accidents affect your employment? ____ If yes, please explain

   _____

I certify that I have read and understand the above information. To the best of my knowledge the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

_____ _____

Patient Signature Date

_____ _____

Doctor's Signature (upon review) Date

HEALTH QUESTIONNAIRE

PLEASE CHECK ALL THAT APPLY:

MUSCULO SKELETAL SYSTEM

___ Low back problems
___ Pain between shoulders
___ Neck problems
___ Arm problems
___ Leg problems
___ Swollen joints
___ Painful joints
___ Stiff joints
___ Sore muscles
___ Weak muscles
___ Walking problems
___ Rupture
___ Broken bones

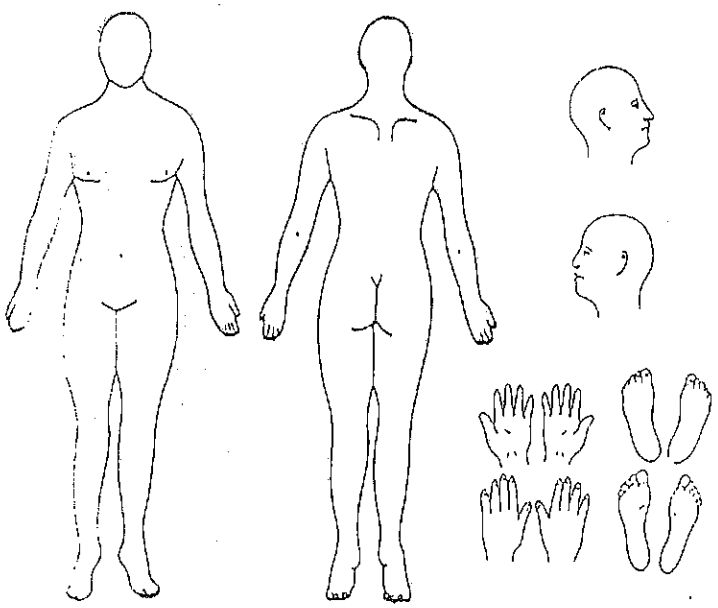
GENITO-URINARY SYSTEM

___ Bladder trouble
___ Excessive urination
___ Scanty urination
___ Painful urination
___ Discolored urine

FEMALE

___ Vaginal discharge
___ Vaginal bleeding
___ Vaginal pain
___ Breast pain
___ Lumps on breast

Are you pregnant?
___ Yes ___ No



GASTRO-INTESTINAL SYSTEM

___ Poor appetite
___ Excessive hunger
___ Difficult chewing
___ Difficult swallowing
___ Excessive thirst
___ Nausea
___ Vomiting food
___ Vomiting blood
___ Abdominal pain
___ Diarrhea
___ Constipation
___ Black stool
___ Bloody stool
___ Hemorrhoids
___ Liver trouble
___ Gall bladder problems
___ Weight trouble

NERVOUS SYSTEM

___ Numbness
___ Loss of feeling
___ Paralysis
___ Dizziness
___ Fainting
___ Headaches
___ Muscle jerking
___ Convulsions
___ Forgetfulness
___ Confusion
___ Depression

CARDIO VASCULAR RESPIRATORY SYSTEM

___ Chest pain
___ Pain over heart
___ Difficult breathing
___ Persistent cough
___ Coughing phlegm
___ Coughing blood
___ Rapid heartbeat
___ Blood pressure problems
___ Heart problems
___ Lung problems
___ Varicose veins

EYES, EAR, NOSE AND THROAT

___ Eye strain
___ Eye inflammation
___ Vision problems
___ Ear pain
___ Ear noises
___ Hearing loss
___ Ear discharge
___ Nose pain
___ Nose bleeding
___ Nose discharge
___ Difficulty breathing thru nose
___ Sore gums
___ Dental problems
___ Sore mouth
___ Sore throat
___ Hoarseness
___ Difficult speech

Patient's Signature

**********DO NOT WRITE BELOW THIS LINE**********

Patient Accepted? Yes No Doctor's Signature

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

(1) I hereby authorize (name of provider) _____

(2) To discuss the following information from the health records of:

Patient name: _____ Date of birth: _____

Address: _____ Telephone: _____

_____ Medical Record Number: _____

Dates of Service: post MVA on

(3) Information to be disclosed:

(A) ☐ complete health record(s)
- ☑ history & physical
- ☑ x-ray reports
- ☐ other (please specify) _____
- ☑ discharge summary
- ☑ progress notes
- ☑ laboratory tests
- ☐ billing records

(B) I understand that this will include information relating to (check if applicable): *(If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from re-disclosing such information without my authorization unless permitted to do so under federal or state law.)*

- ☐ acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV) infection
- ☐ behavioral health services/psychiatric care
- ☐ treatment for alcohol and/or drug abuse
- ☐ domestic abuse

Initials: _____

(4) At the request of the patient, this information is to be released to: South Shore Chiropractic, PC
700 Horseblock Rd.
Farmingville, NY 11738

for the purpose of: Treatment

(5) I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire 12 months from the date signed. I understand that signing this authorization is voluntary. I also understand I may refuse to sign this form and that my health care and payment will not be affected.

Date: _____ Initials: _____

(6) The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for the above disclosure of the above information to the extent indicated and authorized herein.

(7) I may request a copy of this form after signing.

(8) Information disclosed under this authorization might be re-disclosed by the recipient (except as noted in 3 B) and this re-disclosure may no longer be protected by federal or state law.

Initials: _____

Signed: _____
(patient) (this form to be completed before signing) (date)

_____
(legal representative) (relationship to patient – description of authority) (date)

_____
(signature of witness) (relationship to patient) (date)

Note: Release of all confidential information is governed by State and Federal and HIPAA Regulations.
06/04/04

South Shore Chiropractic, P.C.

700 Horseblock Rd.
Farmingville, NY 11738
Telephone: (631) 732 – 1386
Fax: (631) 732 – 1544

450 William Floyd Parkway
Shirley, NY 11967
Telephone: (631) 395 – 8520
Fax: (631) 395 – 8521

sschiropractic@optonline.net

Patient Acknowledgement

Please be advised that being a No-Fault patient of South Shore Chiropractic, PC there are a few responsibilities that you have. Please read the following statements and initial next to each responsibility. If there is anything that you do not understand please feel free to ask and we will clarify it for you.

_____ - I acknowledge that at some point throughout my treatment I will be requested by my No-fault insurance carrier to comply with an independent medical exam (IME) appointment. I must go to any and all of these appointments; ***failure to attend an IME is a violation of your no-fault policy and your insurance carrier does not have to pay any of your outstanding bills. This will result in a complete denial of your claim.*** If this occurs I ***can*** be held responsible for any outstanding medical costs that have not been paid for to date.

_____- If I do fail to attend an IME I will make every attempt to rectify the issue and keep the office notified of the status.

_____- I acknowledge the fact that my No-fault policy may have a personal injury deductible, which I may be responsible for.

_____- I understand that I will **not incur any additional costs** during the course of my treatment with the exception of this deductible or if I breach my policy by not attending the request for an IME.

_____- To avoid any confusion, please let us know when you receive a request to attend an IME.

Patient's Signature _____ Date_____

South Shore Chiropractic, P.C.

700 Horseblock Road
Farmingville, NY 11738

450 William Floyd Parkway
Shirley, NY 11967

Telephone: (631) 732 – 1386
Fax: (631) 732-1544
sschiropractic@optonline.net

Notice of Doctor's Lien

To: _____
_____
_____

Patient Name: _____
Date Of Accident: _____
What Lien is for: _____
Amount Owed: _____

I hereby authorize 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 this office and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect 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 a result of the injuries for which I have been treated or injuries in connection therewith.

I agree never to rescind this document and that a recession will not be honored by my attorney. I hereby instruct that in the event another attorney is substituted in this matter, the new attorney honor this Lien as inherent to the settlement and enforceable upon the case as if it were executed by him.

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 doctor's additional protection and 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. Furthermore, I understand that in the event that I fail to attend any IME appointments or otherwise breach the terms of my insurance policy, I will incur any and all costs not paid to said doctor.

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 said doctor above named. Attorney further agrees that in the event this Lien is litigated that the prevailing party with bee awarded attorney fees and costs.

Attorney Signature: _____ **Date:** _____

I accept the terms stated above. 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.

Patient's Signature: _____ **Date:** _____

South Shore Chiropractic, P.C.

700 Horseblock Rd.
Farmingville, NY 11738
Telephone: (631) 732 – 1386

450 William Floyd Parkway
Shirley, NY 11967
Telephone: (631) 395 – 8520

Fax: (631) 732 – 1544
sschiropractic@optonline.net

Chiropractic Informed Consent To Treat

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, and/or other tests on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who nor or in the future treat me while employed by, working, or associated with or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office clinic personnel the nature and purpose of chiropractic adjustments and procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including, but not limited to, fractures, disc injuries, strokes, dislocations, falls, dizziness, headaches, burns with modalities and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, and is in my best interests.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Dr. Michael J. Campo Dr. Jayesh Patel Dr. Marc Avvento

_____ _____

Patient Signature (or patient representative) Date

(indicate relationship if signing for patient) _____

NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW
ASSIGNMENT OF BENEFITS FORM

(FOR ACCIDENTS OCCURRING ON AND AFTER 3/1/02)

I, _____, ("Assignor") hereby assign to South Shore Chiropractic, PC, ("Assignee")
(Print patient's name) (Print hospital or health care provider name)
all rights privileges and remedies to payment for health care services provided by assignee to which I am entitled under Article 51 (the No-Fault statute) of the Insurance Law.

The Assignee hereby certifies that they have not received any payment from or on behalf of the Assignor and shall not pursue payment directly from the Assignor for services provided by said Assignee for injuries sustained due to the motor vehicle accident which occurred on _____, not withstanding any other agreement
(Print accident date)
to the contrary.

This agreement may be revoked by the assignee when benefits are not payable based upon the assignor's lack of coverage and/or violation of a policy condition due to the actions or conduct of the assignor.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR COMMERCIAL INSURANCE OR A STATEMENT OF CLAIM FOR ANY COMMERCIAL OR PERSONAL INSURANCE BENEFITS CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, AND ANY PERSON WHO, IN CONNECTION WITH SUCH APPLICATION OR CLAIM, KNOWINGLY MAKES OR KNOWINGLY ASSISTS, ABETS, SOLICITS OR CONSPIRES WITH ANOTHER TO MAKE A FALSE REPORT OF THE THEFT, DESTRUCTION, DAMAGE OR CONVERSION OF ANY MOTOR VEHICLE TO A LAW ENFORCEMENT AGENCY, THE DEPARTMENT OF MOTOR VEHICLES OR AN INSURANCE COMPANY, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE VALUE OF THE SUBJECT MOTOR VEHICLE OR STATED CLAIM FOR EACH VIOLATION.

_____ _____
(Print name of Patient) (Signature of Patient)

_____ _____
(Date of signature)

_____
(Address of Patient)

_____ _____
(Print name of Provider) (Signature of Provider)

700 Horseblock Road _____
(Date of signature)

Farmingville, NY 11738
(Address of Provider)

NYS FORM NF-AOB (Rev 1/2004)