

AUTOMOBILE ACCIDENT/INJURY QUESTIONNAIRE

Name: (Last, First MI) _____ Today's Date: _____

Name of Driver, if not self: _____

Car Make _____ Car Model _____ Year _____

Name of Driver of the *other* vehicle: _____

Car Make _____ Car Model _____ Year _____

Date of Accident: ____/____/____ Time ____:____ AM/PM

AUTO INSURANCE INFORMATION

Your Auto Ins: _____ Policy #: _____

Claim #: _____ Phone #: _____

Address: _____ City: _____

State: _____ Zip: _____

Other's Auto Ins: _____ Policy #: _____

Claim #: _____ Phone #: _____

Address: _____ City: _____

State: _____ Zip: _____

ACCIDENT INFORMATION (PLEASE ANSWER ALL QUESTIONS)

Location of Accident: _____

Briefly Explain what happened: _____

WHERE were you sitting in the vehicle?

Front seat – Driver OR Passenger Rear Seat– Behind Driver Middle Behind Passenger 2nd Row 3rd Row

Were you using a seatbelt? No Yes Did the airbags deploy? No Yes

Did you receive an injury to the head? No Yes Knocked unconscious? No Yes (How long?) _____

Were you surprised by the impact? No Yes

AUTOMOBILE ACCIDENT/INJURY QUESTIONNAIRE

Name: (Last, First MI) _____ Today's Date: _____

AT THE TIME OF THE ACCIDENT

Additional symptoms at the time of the accident? Anxiety Exhaustion Stunned Other: _____

Did you feel pain immediately after the accident? No Yes Later that day Next day When? _____

Describe the discomfort AT THE TIME of the accident. Aching Burning Dull Sharp Stiff Tingling

Where were symptoms felt AT THE TIME of the accident? Neck Upper back Lower back Other _____

Did you receive treatment? Primary Care Self Treated @ Home with: rest elevation heat ice

Have you had imaging of your areas of complaint? (MRI, CT, X-Rays) No Yes WHEN: _____ WHERE: _____

SINCE THE ACCIDENT

Are your symptoms? Improving Getting Worse Same

Are your work activities restricted because of this accident/injury? No Yes
(How?) _____

Have you missed any work since this accident? No Yes (Dates?) _____

On a scale from 0 to 10, In the past week how has your pain interfered with your daily activities (I.E Work, social activities, Household Chores)

0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10

Have you retained an Attorney? No Yes

Name: _____ Phone: _____

Address: _____ City: _____

State: _____ Zip: _____

Diagram:

INTRODUCTION PATIENT CASE HISTORY

Name: _____ Date: _____

Preferred Name: _____ Email: _____

Address: _____ City: _____

State: _____ Zip: _____

Home Phone: _____ Mobile #: _____

Gender: M F Marital Status: Single Married Other

Social Security #: _____ Date of Birth: _____

Referred By: _____ Existing Patient Insurance Internet: Google/Yahoo/Yelp Other Source

EMERGENCY CONTACT INFORMATION

Name: _____ Home: _____ Mobile: _____

Relationship: Child Parent Spouse Other: _____

Primary Care Physician: _____ Doctor's Phone: _____

FINANCIAL INFORMATION

Insurance Worker's Comp Self-Pay (Cash) Personal Injury/Auto Other: _____

SYSTEMS REVIEW Please check all of the following that apply to you.

- | | |
|---|--|
| <input type="checkbox"/> Stroke Date: _____ | <input type="checkbox"/> Currently Pregnant, # weeks _____ |
| <input type="checkbox"/> Dizziness / Fainting | <input type="checkbox"/> Abnormal Weight <input type="checkbox"/> Gain <input type="checkbox"/> Loss |
| <input type="checkbox"/> Numbness in Groin / Buttocks | <input type="checkbox"/> Marked Morning Pain/Stiffness |
| <input type="checkbox"/> Epilepsy / Seizures | <input type="checkbox"/> Pain at Night |
| <input type="checkbox"/> Visual Disturbances | <input type="checkbox"/> Cancer / Tumor (explain) _____ |
| <input type="checkbox"/> High Blood Pressure | _____ |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Medications: _____ |
| <input type="checkbox"/> Corticosteroid Use (Cortisone, prednisone, etc.) | _____ |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Surgeries: _____ |
| <input type="checkbox"/> Recent Fall Date: _____ | _____ |
| <input type="checkbox"/> Recent Fever | <input type="checkbox"/> Other Health Problems (explain) _____ |
| | _____ |

PLEASE FEEL FREE TO USE REVERSE SIDE OF PAPER – Copies of Medications/Surgeries Welcome

FAMILY HISTORY

- | | | |
|---|---|--|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Heart Problems/ Stroke | <input type="checkbox"/> Rheumatoid Arthritis | |

IT IS USUAL AND CUSTOMARY TO PAY FOR SERVICES AS RENDERED UNLESS OTHERWISE ARRANGED

HISTORY OF CURRENT CONDITION

NAME: _____ DATE: _____

Major Complaint: _____

When did it start (Date): _____ What event caused it: _____

Intensity: None (0) Mild (1-2) Mild-Moderate (2-4) Moderate (4-6) Moderarate–Severe (6-8) Severe (8-9)

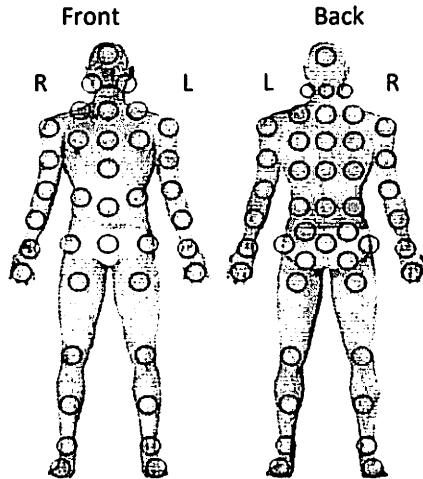
Is the complaint New / Reoccurring Does it Radiate to additional area of your body? No / Yes

If Yes Where: _____

Is the complaint: Aching / Dull / Burning / Sharp / Stabbing / Stiff / Numb-tingling / Other: _____

Have you had this condition before? Yes / No

Mark areas of complaint



Is the complaint getting : Better / Same / Worse from when it started most recently?

How often do you feel the discomfort? 16+ hours / 10-16 hours / 7-10 hours / 3-7 hours / 1-3 hours

What makes it feel better: Ice / Heat / Rest / Massage / Stretching / OTC Meds / RX Meds / Other: _____

Who else have you seen for this complaint: No One / Chiro / MD / PT / Massage / ER / Other: _____

Diagnostic Tests: None / X-rays / MRI / CT / Other: _____ Where & When _____

What makes it feel worse: (Check below)

	Immediately	After 5 min.	After 10 min.	Other		Immediately	After 5 min.	After 10 min.	Other
<i>Standing</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<i>Sit</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Walking</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<i>Household Chores</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Drive Car</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<i>Reach overhead</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Cooking</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<i>Use computer</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Lie Down</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
					<i>(other)</i>				

Where is your #2 COMPLAINT located??? and DESCRIBE IT

Surprise Chiropractic

14545 West Grand Avenue, Suite A106, Surprise, AZ 85374

623-544-9111 – Office / 623-544-9333 - Fax

Dr. Louis V. Verloop, D.C.

INFORMED CONSENT TO CHIROPRACTIC TREATMENT

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures including various modes of therapeutic procedures, and if necessary, diagnostic x-rays on me (or on the patient named below, for whom I am legally responsible: _____) by the chiropractic physician and/or anyone working in this office authorized by the chiropractic physician.

I further understand that such chiropractic services may be performed by the Physician of Chiropractic named here Dr. Louis V. Verloop and/or other licensed Physicians of Chiropractic who may treat me now or in the future at this office. I have had an opportunity to discuss with Dr. Louis V. Verloop, D.C. and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine and all healthcare, the practice of chiropractic carries some risks to treatment; including, but not limited to: fractures, disc injuries, strokes (CVA), dislocations, and sprains. I do not expect the chiropractic physician to be able to anticipate and explain all risks and complications. Further, I wish to rely on the chiropractic physician to exercise judgment during the course of the procedure which the chiropractic physician feels are in my best interests at the time, based upon the facts then known.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its contents, and by signing below, I agree to the treatment recommended by my chiropractic physician. I intend this consent form to cover the entire course of treatment for my present condition(s) and for any condition(s) for which I seek treatment at this facility.

To be completed by the *Patient*:

Print Name of Patient

Signature of Patient

To be completed by the *Patient's Representative*, if patient is a minor or is physically or mentally incapacitated:

Print Name of Patient

Print Name of Representative

Signature of Representative

Form to be maintained in the patient's health record.

SURPRISE CHIROPRACTIC

Louis Verloop, D.C

14545 W Grand Ave suite # A106, Surprise, AZ 85374

P : 623-544-9111 F: 623-544-9333

• **INSURANCE INFORMATION**

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and me. Furthermore, I understand that this Chiropractic Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this Chiropractic Office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, and that the fees for the professional services rendered to me will be immediately due and payable.

Initial: _____

• **ASSIGNMENT OF BENEFITS**

I hereby authorize Surprise Chiropractic, LLC to release any information necessary to process this claim and assign ALL BENEFITS payable directly to Surprise Chiropractic, LLC.

I waive the Statute of Limitations regarding my chiropractic physician's right to recover.

I understand that whatever amount is not collected from insurance proceeds, (whether it be all or part, when insurance benefits exhaust or are denied for whatever reason), I am personally responsible.

If collection or legal action should become necessary in payment of services rendered by Surprise Chiropractic, LLC, I understand that I will be personally responsible for all fees incurred by Surprise Chiropractic, LLC, made to collect that payment due.

Initial: _____

• **CONSENT OF PROFESSIONAL SERVICES & RELEASE OF INFORMATION**

I hereby authorize and release the chiropractic physician and whomever he/she may designate as his/her assistants to administer treatment, physical examination, X-ray studies, laboratory procedures, chiropractic care or any clinic services that he/she deems necessary in my case; and I further authorize him/her to disclose all or any part of my (patient's) record to any person of corporation which is or may be liable under a contract to the clinic or to the patient or to the family member or employer of the patient for all or part of the clinic's charge, including, and not limited to, hospital or medical services companies, workers compensation carriers, welfare funds, or the patient's employer.

Initial: _____

• **ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

I understand that I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the healthcare providers who may be directly and indirectly involved in providing my treatment.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and accreditation.
- We can accommodate your need for further privacy or information if you deem necessary, please let us know.

Initial: _____

By initialing the above and signing this document, I acknowledge and understand my rights as a patient.

Printed Name: _____ **DOB:** _____

Patient Signature: _____ **DATE:** _____

SURPRISE CHIROPRACTIC

Dr. Louis Verloop, D.C.

14545 W Grand Ave suite # A106, Surprise, AZ 85374

Phone : 623-544-9111 Fax : 623-544-9333

Authorization and Assignment of Benefits

You, Surprise Chiropractic are authorized to release any information that you, Surprise Chiropractic, deem appropriate concerning my physical condition for reimbursement of charges incurred.

In that this office is waiting for payment of some of its fee, I agree to provide Surprise Chiropractic with information and forms regarding any potential source of fee payment to assist in any way I can, and I hereby assign to Surprise Chiropractic my rights to receive payment from negligent parties and from insurance companies. Payment should be payable to and mailed to surprise Chiropractic at the above address. If my policy prohibits assignment, then checks should be made jointly to me and Surprise Chiropractic and mailed to the above address. I authorize the direct payment to you (Surprise Chiropractic) of any sum I now or hereafter owe you, by my attorney, out of the proceeds of any settlement of my case, and/or by any insurance company obligated to me or you based in whole or in part upon the charges made for services.

I understand that if Surprise Chiropractic receives more than their fees, Surprise Chiropractic will pay the credited amount to me, the patient.

I permit Surprise Chiropractic to endorse co-issued remittance for the convenience of credit to my account.

In the event any insurance company, obligated by contractual agreement, to make payment to me or towards your services refuse to make such payment upon demand, I hereby assign and transfer to you, Surprise Chiropractic the cause of action that exits in my favor against any such companies, the names of which is believed to correctly set forth under pertinent data and authorize you to prosecute said action in my name as you see fit and further authorize you to compromise, settle or otherwise resolve said claim as you see fit. However, it is understood that until a reasonable effort had been made to collect the sums due from any insurance company or companies contractually obligated, you Surprise Chiropractic will refrain from collecting the amounts owed directly from me. I understand that whatever amounts you do not collect from the insurance company's proceeds, whether it be all or part of what is due, I personally owe and agree to pay you.

In addition to the above, I hereby waive the statute of limitations on collection and/or recovery in the state of AZ.

I further agree that this authorization and assignment is irrevocable and ongoing until all monies owed are paid in full.

This authorization for assignment will be in continual effect until revoked by both parties.

This document shall not be superseded by any other document sent to you, if any, by my attorney pertaining to disbursement of funds for my medical bills.

A photocopy of this form shall be valid as the original.

In the event of default, I agree to pay for collections and/or attorney fees.

Notice of Medical County Lien (For patients who have an auto accident or other personal injury claim) In order to ensure that the parties liable for payment of your claim are fully aware of the fact that Surprise Chiropractic is extending credit to you for your care in our office, we will be filing a medical county lien. This lien will be released once payment has been paid by all responsible parties.

Signature of Patient _____ Date _____

SURPRISE CHIROPRACTIC

Louis Verloop, D.C.
14545 W Grand Ave Suite # A106
Surprise Az 85374
Phone: 623-544-9111
Fax: 623-544-9333

Attorney Authorization/Lien

Attorney Name: _____

Patient Name: _____

Address: _____

City, State, Zip: _____

Date of Birth: _____

I do hereby authorize Surprise Chiropractic to furnish you, my attorney, with a full report of the examination, diagnosis, treatment, prognosis, complete billing and any other pertinent information regarding my care as a result of the accident in which I was involved.

I hereby authorize and direct you, my attorney, to pay directly to said doctor's office such sums as may be due and owing them for medical services rendered to me both by reason of this accident and by reason of any other bills that are due his office and to withhold such sums from any settlement, medical insurance payment, judgment or verdict, as may be necessary to adequately protect said doctor's office. I hereby further give a lien on my case said doctor's office against any and all proceeds of my settlement, medical insurance payment, judgment or verdicts which may be paid to you, my attorney, or to myself as a result of the injuries for which I have been treated or injuries connected therewith.

I understand that I am directly and fully responsible to said doctor's office for all medical bills submitted by him for services rendered to me, and that this agreement is made solely for said doctor's additional protection, and in consideration of his awaiting payment, judgment or verdict by which I may eventually recover said fee.

Patient Signature: _____ Date: _____

The undersigned, being attorney of record for the above patient, does hereby agree to observe all the items of the above and agrees to withhold such sums for any settlement, medical insurance payment, judgment or verdict as may be necessary to adequately protect said doctor's office named above.

Attorney Signature: _____ Date: _____