AUTOMOBILE ACCIDENT/INJURY QUESTIONNAIRE

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

Name of Driver, ***if not self*****:** _____ **DOB**_____

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: _____

_____

_____

_____

_____

_____

_____

AUTOMOBILE ACCIDENT/INJURY QUESTIONNAIRE

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

ACCIDENT INFORMATION

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* **Lose unconscious?** ☐ *No* ☐ *Yes (How long?)* _____

AT THE TIME OF THE ACCIDENT

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

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

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

Did you receive treatment? ☐ ***Primary Care*** ☐ ***Hospital/Urgent care*** ☐ ***Self Treated @ Home with:*** ☐ *rest* ☐ *heat* ☐ *ice*

What type of treatment was received after collision? _____ **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:** _____

Additional Notes:

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.**

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

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

FAMILY HISTORY

- ☐ Cancer
- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ Heart Problems/ Stroke
- ☐ Rheumatoid Arthritis

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

S/C 12/05/16

History of Current Condition

NAME:_____ **DATE:**_____

Major Complaint: _____

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

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

Please Circle Pain Intensity Below

0: No Pain

1-2: Mild Pain

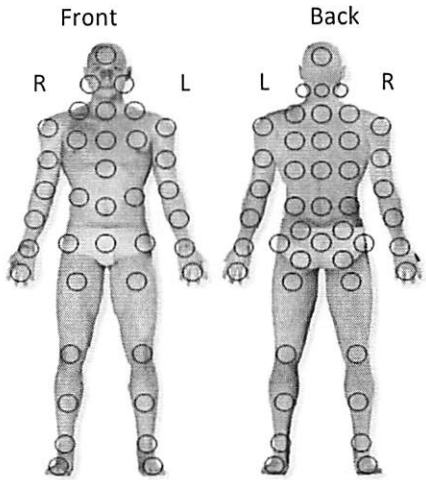
2-4: Mild - Moderate Pain

4-6: Moderate Pain

6-8: Moderate - Severe Pain

8-9: Severe Pain

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
Standing	☐	☐	☐	☐
Walking	☐	☐	☐	☐
Drive Car	☐	☐	☐	☐
Cooking	☐	☐	☐	☐
Lie Down	☐	☐	☐	☐

	Immediately	After 5 min.	After 10 min.	Other
Sit	☐	☐	☐	☐
Household Chores	☐	☐	☐	☐
Reach overhead	☐	☐	☐	☐
Use computer	☐	☐	☐	☐
_____ ***(other)***	☐	☐	☐	☐

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

_____

SURPRISE CHIROPRACTIC

Louis Verloop, D.C

14515 W Grand Ave suite #C128, 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 waiver 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

14515 West Grand Avenue, Suite C128, 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.
Derek Legg, D.C.
14515 W Grand Ave suite #128, 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.
Derek Legg, D.C.
14515 W Grand Ave Suite #128
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: _____