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HOBOKEN, NJ 07030
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PERSONAL INJURY / ACCIDENT MEDICAL HISTORY INTAKE FORM

(Mark a check on each that applies)

Referred by: Account No.: Date:

Full Name:

Gender: M F Marital Status: Single Married Widowed Separated Divorced Age:

Birth Date: Height Weight

Address:

City: State: Zip:

Social Security No.: Driver's License No.:

Home Phone: Cellular Phone.:

Who Referred you:

Employer: Work Phone: ()

Email:

INSURANCE / ATTORNEY INFORMATION:

Insured's Name: (Last) (First) (Init)

Relation to patient: D.O.B.: Soc. Sec. #:

Insurance Company:

ID#: Group #:

Do you have MedPay? Yes No Were you at fault? Yes No

Have you retained an attorney? Yes / No

Your Attorney's Name:

Your Attorney's Phone: () Fax ()

Your Attorney's Address:

City: State: Zip:

ACCIDENT INFORMATION:

Date of Accident: Time of Accident: a.m. / p.m.

Your Vehicle: Year Make Model

Other Vehicle: Year Make Model

Seat Belt: Yes No Accident Type: Rear ended Head-on Broad-sided

Damage to Your Vehicle: \$ _____

Other Vehicle Damage: \$ _____

Describe Accident: _____

ACCIDENT SPECIFICS: (Mark a ✓ on each that applies to the accident)

Was this injury accident related? Yes No Auto Work Other

Was this a Job or Work related injury: Yes No Were you the: Driver Passenger

If passenger, where were you sitting: Front Seat Back Seat

Were you wearing your seatbelt: Yes No Did the airbag deploy: Yes No

Impending Collision, were you: Aware Unaware Braced Not braced

Did your head: Strike Object Not strike Object Break Glass Other

Did you experience: Shock Loss of Consciousness Whiplash Other

The Weather Conditions were they: Sunny Raining Snowing Foggy

The Road was: Dry Wet Icy Time of Day: Dawn Day Dusk Night

State your emotions and physical state immediately following the accident: _____

State your emotions & physical state after the first few days: _____

IMMEDIATELY FOLLOWING THE ACCIDENT: (Mark a ✓ on each that applies to the accident)

Ambulance / Paramedics were called

I was treated at the scene

I was transported to Hospital by Ambulance

I went to Hospital in my own

I was diagnosed at the Hospital

I was treated at the Hospital

Medication was prescribed

Follow-up was recommended

OTHER DOCTORS SEEN:

Orthopedist Neurologist Psychiatrist Physiatrist Chiropractor

Acupuncturist General Practitioner Physical Therapist Massage Therapist

Other

SYMPTOMATOLOGY: (Pain characteristics for major area of complaint)

The pain started: _____

The pain is made **better** by: _____

and **worse** by _____

How do the following activities affect your pain?

	No Change	Relieves	Increased	Duration
Sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lying Down	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Looking up	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Looking Down	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lifting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

PROGRESSION:

How is your pain compared to when the pain episode first started?

Much Improved Somewhat Improved Much Worse Somewhat Worse No Change

What do you do to relieve the pain?

Please mark a ✓ on each that applies to your daily activities:

- Have difficulty climbing stairs.
- Have to use handrails to get up stairs, etc.
- Have to hold onto something to sit or stand from a chair.
- Stay at home most of the time.
- Do not do jobs around the house.
- Walk slower than usual.
- Can only walk short distances.
- Have to sit most of the day.
- Can only stand for short periods of time.
- Stays in bed most of the day.
- Change position frequently to try and get comfortable.
- Have difficulty turning over in bed.
- Have to lie down and rest frequently.
- Have difficulty sleeping.
- Have to get other people to do things for me.
- Have difficulty getting dressed.
- Have to get dressed with someone's help.
- Have difficulty bending or kneeling.
- Have a loss of appetite.
- Have more irritable stages.

What are some recreational activities that you participated in before this current problem and which ones cannot be performed now to the same extent as before?

How often do you have to stop activities and sit or lie down to control your symptoms?

Several Times Occasionally Approximately _____ per day Never All Day

List your hobbies & exercise activities _____

SOCIAL HISTORY:

Smoker Non-Smoker Do not drink alcohol Drink alcohol

How much? _____ How often? _____

Do not take drugs Take Drugs How much? _____ How often? _____

Number of Children: _____

MEDICAL HISTORY:

List any medical professionals you have seen for this problem: _____

List any medications you are currently taking: _____

List the treatments you have had for your problem:

Chiropractic Osteopathy Trigger Point Injections Epidural Injections
 Acupuncture Hot packs Ultrasound Massage
 Electrical Stimulation Strengthening Exercises Aerobics
 Bed Rest Back Brace Other: _____

List the types of Diagnostic Testing that has been performed for this problem:

X-Rays C.T. Scan M.R.I. Scan Discogram Bone Scan
 E.M.G.

List Past Surgeries: None

List Past Hospitalizations: None

List previous back, neck and musculoskeletal problems:

MEDICAL HISTORY:

Do you have or have you ever had diseases or conditions of (please check Yes or No)

Respiratory:

- Bronchitis Yes No
- Emphysema No
- Asthma Yes No
- Chronic Cough Yes No
- Morning Cough Yes No
- Shortness of Breath Yes No
- Wheezing Yes No

Cardiovascular:

- High Blood Pressure Yes No
- Chest Pain Yes No
- Heart Attack Yes No
- Heart Murmur Yes No
- Arrhythmia Yes No
- Phlebitis Yes No
- Hardening of the Arteries Yes No
- Artificial Valve Yes No
- Pacemaker Yes No

Other Systemic:

- Hepatitis Yes No
- Diabetes Yes No
- Thyroid Problems Yes No
- Kidney Disease Yes No
- Dialysis Yes No
- Bladder Problems Yes No

Gastrointestinal

- Stomach absorptive disorder Yes No
- Nausea, vomiting, diarrhea when taking antibiotics Yes No
- Yeast infection when taking antibiotics Yes No
- Arthritis/joint Deformity Yes No
- Artificial Joint Yes No
- Convulsions Yes No
- Epilepsy, Seizures Yes No
- Fainting Yes No

Do you have any current problems with:

- Anxiety Depression Irritability Other: _____

Do you have a home exercise program that you follow on a regular basis?

- Yes No

NOTES:

Signature

Date

ASSIGNMENT, LIEN, AUTHORIZATION OF INSURANCE BENEFITS AND POWER OF ATTORNEY

Name of Patient: _____

Date of Accident: _____

I hereby authorize and direct any insurance company and/or my attorney to pay directly The Spine & Sports Health Center such sums as may be due and owing the office for services rendered to me, both by reason of accident or illness, and by reason of any other bills that are due this office, and to withhold such sums from any disability benefits, or any other insurance benefits obligated to reimburse me or from any settlement, judgment or verdict on my behalf as may be necessary to adequately protect said Office

I hereby further give a lien to said Office against any and all insurance benefits that I may be entitled to and any and all proceeds for any settlement, judgment or verdict which may be paid to me as a result of the injuries or illness for which I have been treated by said Office. This is to act as an assignment of my rights and benefits to the extent of the Office's services provided.

I hereby assign all of my interest and rights to PIP benefits, which shall include, but not be limited to the right to file a PIP suit or seek arbitration for PIP benefits relative to treatment by said Office. I hereby assign and transfer to this Office any and all causes of action that I might have or that might exist in my favor against any insurance carrier that may be liable for payment of PIP benefits, and authorize this Office to prosecute said cause of action either in my name or in the Office's name and further I authorize this Office to compromise, settle or otherwise resolve said claim or cause of action as they see fit. Further, in the event that the within assignment is not consented to by an insurer or in any other manner is held invalid by any party, arbitrator or any other person, I hereby give this Office the power of attorney to bring any arbitration proceeding or suit in my name on my behalf as if I had filed such action myself. I further agree to fully cooperate with regard to prosecuting such action or proceeding.

I understand that I remain personally responsible for the total amounts due the Office for services, subject to New Jersey Law. I further understand and agree that this Assignment, Lien, and Authorization does not constitute any consideration for the Office to await payments and they may demand payments from me immediately upon rendering services at their option. I further understand and agree should I receive any payments made on my behalf from any insurance company I will endorse the check over to The Spine & Sports Health Center within 30 days of my receipt of same and fully understand that failure to do so will result in collections procedures against me.

I authorize this Office to release any information pertinent to my case to any insurance company, adjuster, or attorney to facilitate collection under this Assignment, Lien, and Authorization, so long as the request is submitted in writing. I agree that the above mentioned Office is hereby given Power of Attorney to endorse/sign my name on any and all checks for payment of my doctor's bill. I further authorize any insurance company and any other physicians who have treated me for this accident to provide this Office with any documentation needed, with regard to the payment of my bills.

Date: _____

Patient Signature: _____

PATIENT NAME: _____

INSURANCE INFORMATION:

Date of Accident: _____

Ins. Company: _____

Policy #: _____

Claim #: _____

Adjuster's name: _____

Phone #: _____

Fax #: _____

Benefits available: Policy Limit \$ _____ PT BEN _____

LAWYER INFORMATION:

Lawyer: _____

Address: _____

Phone: _____

Fax: _____

Contact Person: _____

Spoke With: _____ Date: _____ Time _____

To: _____

Re: Medical Reports and Doctor's Lien

I authorized the above doctor and/or their authorized representatives to furnish my attorney, any attorney or attorneys who subsequently are either associated with the said attorney or substituted in their place, with a full report of my examination, diagnosis, treatment, prognosis, itemized bill of charges incurred, etc. in regard to the accident in which I was involved on _____, and hold the above doctor free and harmless from any liability in such transfer of information.

Out of the proceeds of the settlement and/or judgment in my claim for personal injuries, I hereby assign, set over and transfer to the above doctor such monies due and owing to him or the group for medical, chiropractic, x-rays, physical therapy, supplies and/or laboratory fees rendered to me, either by reason of the above accident or otherwise. I further give to the above doctor a lien on any and all funds received by me or in my behalf in association with the settlement or satisfaction of judgment arising from claims presented on my behalf.

I fully understand that I am directly responsible to said doctors/group for all medical bills submitted by them for services rendered to me. I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually receive said fee. In the event legal action shall be brought in order to enforce this lien, then the prevailing party shall be entitled to reasonable costs and attorney fees in addition to any judgment rendered. It is acknowledged by the undersigned that this assignment and lien is further consideration for the services rendered by the above doctor in addition to the obligation to pay for the medical services.

Patient's personal injury claim medical payments are hereby assigned and will be paid directly from the insurance company to East Coast Spine, Joint & Sports Medicine.

Attorney agrees to notify the doctors immediately of the name and contacting information of any attorney substituted in his or her place.

PRINT PATIENT NAME

DATE

SIGNATURE OF PATIENT

SIGNATURE OF PARENT/GUARDIAN

ACKNOWLEDGEMENT OF ASSIGNMENT AND LIEN BY ATTORNEY

The undersigned being the attorney of record on his own behalf and on behalf of any other attorney or attorneys who are associated with the undersigned or who are substituted in his stead for the above patient, does hereby acknowledge receipt of a copy of the assignment and lien, and said attorney acknowledges that he/she obligates themselves to the terms of the assignment and lien in consideration for the rendering of medical services to their client by the above doctor and rendering of a report and bill to said attorney. In the event legal action shall be brought in order to enforce this lien, then the prevailing party shall be entitled to reasonable costs and attorney fees in addition to any judgment rendered. A photographic reproduction of this authorization may be used in place of the original. No charges or alterations of the monies billed herein will be accepted unless confirmed in writing by the doctor. Please date, sign and return on copy as soon as possible to the above referenced medical provider of service in order that treatment can continue on the herein contained lien basis.

ATTORNEY'S SIGNATURE

DATE