PATIENT BASIC INFORMATION

Accident/Slip and Fall **Date: _____**

Last Name:	**First Name:**			**MI:**
Address:		**City:**	**State:**	**Zip:**
Home Phone:	**Cell Phone:**		**Social Security Number:**	
Date of Birth:	**Date of Injury/Onset:**			
Dominant Hand:	**____ Right ____ Left ____ Both**			
Employer:	**Occupation:**	**E-mail:**		

How did you hear about our office:_____

Special Note: If your injury involved a motor vehicle, skip to page 2. Otherwise, use the spaces below to fully describe your accident, injury or onset, slip and fall, etc.

1. **Description of Accident / Injury / Onset**

   Enter a full description of the accident, injury or onset in the space below.

2. **Your condition during and immediately after injury / onset**

   Enter the details of your condition during and immediately after your injury / onset.

Automobile Accident Description

Please answer the questions below. If you do not know the answer to any of the questions, do not answer the question.

1. Your vehicle type	2. Your position in vehicle	3. What was your vehicle doing at the time of the accident?
____ Car ____ Station wagon ____ Van ____ Pick up truck ____ Large truck ____ Bus Other _____	___ Driver __ Front passenger ____ Left rear passenger ____ Right rear passenger Other _____	___ Stopped at intersection ___Stopped in traffic ___Stopped at light ___Making a right turn ___Making a left turn ___Parking ___Proceeding along ___Slowing down ___Accelerating Other _____

4. Time/Speed/Damage	5. Details of accident	6. Road conditions
Time of accident _____ Your vehicle's speed _____ Other vehicle's speed _____ Damage to your vehicle ___ Mild ___ Moderate ___ Totaled	Visibility at time of accident ___ Poor ___ Fair ___ Good ___ You hit other vehicle ___ Other vehicle hit you You hit (object) _____	Road conditions at time of accident ___ Icy ___ Wet ___ Sandy ___ Dark ___ Clean and dry Point of Impact ___ Head on ___ Left front ___ Right front ___ Rear end ___ Left rear ___ Right rear

7. Body position, etc..	
Did you see the accident coming? ___Yes ___No Were you braced for the impact? ___Yes ___No Did you have a seat belt on? ___Yes ___No Did you have a shoulder harness on? ___Yes ___No	Does your vehicle have headrests? ___ Yes ___ No What was the position of your headrest at the time of the impact? ___Even with the top of head ___Even with the bottom of head ___Mid neck What was the direction of your head at the time of the impact? ___Facing straight forward ___Turned to the right ___Turned to the left
Did driver side airbags deploy? ___Yes ___No Did passenger side airbags deploy? ___Yes ___No Did side airbags deploy? ___Yes ___No	

8. Additional accident information
In the case of a motor vehicle accident, enter any additional information here that is not covered by the above check offs

9. During the accident	10. After the accident
Did your body strike the inside of your vehicle? ___ Yes ___ No If yes, describe _____ Did you lose consciousness during the injury? ___ Yes ___ No If yes, for how long? _____ Your vehicle's estimated damage? _____ Damage to their vehicle ___ Mild ___ Moderate ___ Totaled Did police show up at the scene? ___ Yes ___ No Was an accident report filled out? ___ Yes ___ No	Check off your symptoms right after and a few days following ___ Headache ___ Dizziness ___ Mid back pain ___ Cold hands ___ Neck pain ___ Nausea ___ Low back pain ___ Cold feet ___ Neck stiffness ___ Confusion ___ Nervousness ___ Diarrhea ___ Fainting ___ Fatigue ___ Loss of taste ___ Depression ___ Ringing in ears ___ Tension ___ Toe numbness ___ Anxious ___ Loss of smell ___ Irritability ___ Constipation ___ Chest pain ___ Pain behind eyes ___Shortness of breath ___ Sleeping problems Others _____

11. Emergency room	12. Treatment history
Where did you go after the accident? ___ Home ___ Work ___ Hospital ER ___ Private Doctor How did you get there? ___ Drove self ___ Somebody else ___ Ambulance ___ Police Were X-rays done? __Yes __No Was lab work done? __Yes __No Body parts X-rayed? _____ What lab work? _____ The X-rays revealed _____ Treatments: ___ Cervical Collar ___ Ice Other _____ Medications _____ Follow-up instructions _____	Fill in any other Doctor(s) seen prior to your first visit to this office 1. Dr. _____ First visit date _____ Specialty _____ Were X-rays done? __Yes __No Types of treatment received _____ How many treatments received?____ Currently treating? __Yes __No Did treatments benefit you? ___Yes ___No Last visit date _____ 2. Dr. _____ First visit date _____ Specialty _____ Were X-rays done? __Yes __No Types of treatment received _____ How many treatments received?____ Currently treating? __Yes __No Did treatments benefit you? ___Yes ___No Last visit date _____

HISTORY

HAVE YOU EVER BEEN INVOLVED IN A WORK RELATED OR AUTO ACCIDENT?

_____

PRIOR TO THIS, HAVE YOU EVER RECEIVED ANY INJURY TO THE AREA(s)NOW INJURED?

_____

HAVE YOU EVER HAD ANY BROKEN BONES? _____

HAVE YOU EVER HAD ANY SURGERIES: _____

DO YOU HAVE ANY PRESENT HEALTH CONDITION: ____Yes ____No IF YES, PLEASE EXPLAIN:

_____

LIST MEDICATIONS YOU TAKE AT THIS TIME: _____

HAVE YOU EXPERIENCED ANY BOWEL OR URINARY CHANGES SINCE THIS CONDITION BEGAN? Explain

_____

DIDYOU ENJOY GOOD HEALTH PRIOR TO THIS INJURY / ONSET: ____Yes ____No

IF NO, PLEASE EXPLAIN: _____

FEMALE: Are you, or could you be pregnant? _____Yes _____No Date of Last Period _____

FAMILY DOCTOR NAME / ADDRESS	**WORK / AUTO ACCIDENT DOCTORS NAMES / ADDRESS**

SOCIAL/OCCUPATIONAL HISTORY

DO YOU USE: _____ Prescription drugs _____ Tobacco _____ Alcohol _____ Recreational drugs

IF YES, PLEASE LIST:_____

MARITAL STATUS _____M ____S ____W ____D HOW MANY CHILDREN IN HOME _____

WERE YOU EMPLOYED WHEN THE ACCIDENT OCCURRED: _____ Yes _____ No

IF YES, WHO WAS YOUR EMPLOYER: _____

DID YOU STOP WORKING DUE TO THE ACCIDENT: _____ Yes _____ No _____ Date

ARE YOU PRESENTLY WORKING: _____ PART TIME _____ FULL TIME _____ NOT WORKING

BEFORE THE ACCIDENT, WHAT TYPE OF WORK WERE YOU REQUIRED TO DO EVERY DAY?

_____

AFTER THE ACCIDENT, WHAT TYPE OF WORK ARE YOU REQUIRED TO DO EVERY DAY?

_____

DOES WORK MAKE YOUR CONDITION WORSE? _____ Yes _____ No

IF YES, PLEASE EXPLAIN: _____

I hereby give authorization for my medical results/records to be sent to my other doctors that I have listed. I hereby give consent for treatment to Brandon Chiropractic and Massage. I hereby certify that the information I have given is true to the best of my knowledge.

SIGNATURE _____ DATE _____

Brandon Chiropractic and Massage

654 E. Bloomingdale Ave., Brandon, FL 33511

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

_____ _____

Patient Name (please print) Date

_____

Parent, Guardian or Patient's legal representative (please print)

_____

Signature

THIS FORM WILL BE PLACED IN THE PATIENT'S CHART AND MAINTAINED FOR SIX YEARS.

LIEN

TO WHOM IT MAY CONCERN:

I HEREBY AUTHORIZE AND DIRECT YOU, MY INSURANCE COMPANY,
AND/OR MY ATTORNEY, TO PAY DIRECTLY TO:

Brandon Chiropractic and Massage
654 E. Bloomingdale Ave.
Brandon, FL 33511

SUCH SUMS AS MAY BE DUE AND OWING THIS OFFICE FOR SERVICES RENDERED ME. THIS 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, MEDICAL PAYMENTS BENEFITS, NO-FAULT BENEFITS, HEALTH AND ACCIDENT BENEFITS, WORKER'S COMPENSATION BENEFITS, OR ANY OTHER INSURANCE BENEFITS REIMBURSABLE TO ME, OR FROM ANY SETTLEMENT, JUDGEMENT OR VERDICT MADE 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 NAMED HEREIN, AND, ANY AND ALL PROCEEDS OF ANY SETTLEMENT, JUDGEMENT 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.

IN THE EVENT MY INSURANCE COMPANY, OBLIGATED TO MAKE PAYMENTS TO ME UPON THE CHARGES MADE BY THIS OFFICE FOR THEIR SERVICES, REFUSES TO MAKE SUCH PAYMENTS, UPON DEMAND BY ME OR THIS 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 SUCH COMPANY 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.

I UNDERSTAND THAT I REMAIN PERSONALLY RESPONSIBLE FOR THE TOTAL AMOUNT DUE THIS OFFICE FOR THEIR SERVICES AND THAT THIS DIRECTIVE / LIEN IS IRREVOCABLE BY ME UNTIL ALL SUCH SUMS ARE VERIFIED BY BRANDON CHIROPRACTIC AND MASSAGE AS PAID IN FULL OR OTHERWISE SATISFIED.

I AUTHORIZE THE 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

_____ _____
PATIENT SIGNATURE DATE

_____
PATIENT'S PRINTED NAME

ATTORNEY: PLEASE DATE, SIGN AND RETURN AT YOUR EARLIEST CONVENIENCE.
THANK YOU.

_____ _____
ATTORNEY SIGNATURE DATE

ASSIGNMENT OF BENEFITS

I hereby authorize and direct you, my insurance company and/or attorney, to pay directly to Wanda I. Nieves-Moreno, D.C., LLC d.b.a. Brandon Chiropractic and Massage ("Assignee"), such sums as may be due and owing Assignee for the services rendered to me, both by reason for accident or illness, and by reason of any other bills that are due Assignee, and to withhold such sums from any disability benefits, medical payment benefits, No-Fault 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 Assignee. In the event that I do not have insurance coverage, I understand that I remain personally responsible for payment of services rendered. I hereby further give an irrevocable lien to said assignee against any and all insurance benefits named herein and any and all proceeds of 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 the Assignee. This is to act as an assignment of my rights and benefits to the extent of the Assignee's services provided.

ASSIGNMENT OF CAUSE OF ACTION

In the event my insurance company is obligated to make payments to me upon charges made by the Assignee for its services refuses to make such payments, upon demand by me or Assignee, I hereby assign and transfer to Assignee any and all causes of action, and proceeds from such action, that I might have or that might exist in my favor against such company and I authorize Assignee to prosecute said cause of action either in my name or Assignee's name and further I authorize Assignee to compromise, settle or otherwise resolve said claim of action as they see fit.

DIRECTION OF PAYMENT

I hereby authorize any insurance company or attorney to pay directly to assignee the amount of this and/or any future bills for services rendered to me. I also agree to pay in a current manner any difference between the total charges and the amount paid by the insurance company directly to Assignee.

POWER OF ATTORNEY

Power of attorney to endorse check and/or to sign any piece of paper, which will enhance or expedite payment to provider for services rendered, including but not limited to a release of medical records and assignment of benefits/authorization to pay. I authorize the above mentioned office to, and hereby give power of attorney to said office to endorse/sign my name on any and all checks for payment of medical services received from my insurance company and grant a lien to said medical services provider for any proceeds or insurance benefits payable under my policy. A photocopy of this instrument shall be considered as effective and valid as the original.

PIP LOG REQUEST

I hereby authorize assignee to release any information requested that is pertinent to my case to my insurance company or attorney involved in this case. Pursuant to §627.4137 Florida Statutes (2001), I hereby request a copy of the pip log and declaration sheet, which reflects the policy limits available at the time of this accident, to be provided to Assignee. I hereby authorize Assignee to request and receive a copy of my pip log periodically as they deem to be necessary.

RESERVATION OF BENEFITS

Please be advised that I am hereby placing you on notice that, pursuant to Florida case law, should you deny, reduce or fail to pay either a portion of or an entire bill submitted on my behalf from this healthcare provider, I am requesting that you reserve, or hold aside, that same amount until this dispute is resolved.

If any term or provision of this Assignment, Lien and Authorization or the application thereof to any person or circumstances shall to any extent be invalid of unenforceable the remainder of this Assignment, Lien and Authorization, or the application of such term or provision to persons to circumstances other than those as to which it is held invalid of unenforceable, shall not be affected thereby, and each term and provision of the Assignment, Lien and Authorization shall be valid and enforced to the fullest extent of the law.

_____ _____

PATIENT SIGNATURE DATE

_____

PATIENT'S PRINTED NAME

Brandon Chiropractic and Massage

654 E. Bloomingdale Ave., Brandon, FL 33511

AUTHORIZATION TO OBTAIN, RELEASE OR REVIEW PROTECTED HEALTH INFORMATION

Patient Name: _____ Social Security No.: _____

Address: _____

Date of Birth: _____ Date of Service: _____ Phone No.: _____

Identification Shown: _____ Mail _____ Pick Up _____

I hereby authorize Brandon Chiropractic and Massage to use and disclose to: _____ or obtain from: _____ or allow review: _____

_____ _____
Name of Facility or Person Phone Number

_____
Street Address City State Zip Code

The following information contained in my medical record regarding my hospitalization, care and treatment (please initial):

_____ Complete Record
_____ Abstract of Record
_____ Therapy Records
_____ Progress Note(s)
_____ All Diagnostic Test Results
_____ Consultation
_____ Radiology Only
_____ Operative Report
_____ Pathology Report(s)
_____ Lab Only
_____ Other (please specify)
_____

The purpose for the release of information at the request of the individual is:

____ Insurance ____ Legal Action ____ Continued Treatment ____ Personal Use
____ Patient Communication (Behavioral Health) ____ Other (please specify) _____

This authorization will expire on the following date, event or condition: _____
I understand that this authorization extends to all or any part of the records designated above, which may include psychiatric information, and/or genetic counseling/testing, and/or alcohol/drug abuse and/or AIDS (Acquired Immunodeficiency Syndrome), and/or may include the result of an HIV test or the fact that an HIV test was performed. I expressly consent to the release of information as designated above unless initialed below or otherwise required by law.

May NOT include information related to (please initial):
_____ HIV/AIDS _____ Mental Health _____ Drug and/or Alcohol Abuse _____ Genetic Counseling/Testing Information

If I fail to specify an expiration event or condition, the authorization will expire in one year. I understand that this authorization is revocable upon written notice to the office where the original authorization is retained, except to the extent that action has already been taken on this authorization. I understand that my protected health information that is used or disclosed under this authorization may be subject to re-disclosure by the recipient and the privacy of my protected health information may no longer be protected by law. I further understand that Brandon Chiropractic and Massage may not condition the provision of treatment, payment, enrollment in the health plan, or eligibility for benefits on the provision of this authorization. I understand that I will receive a signed copy of this form.

_____ _____
Patient/Legal Representative or Parent/Legal Guardian Signature Date

Translator or Interpreter's Name: _____

PIP APPLICATION

_____ ATTN: _____
NAME OF INSURANCE COMPANY CLAIM DEPARTMENT

_____ _____ _____ _____
DATE POLICY HOLDER DATE OF ACCIDENT FILE NO

TO ENABLE US TO DETERMINE IF YOU ARE ENTITLED TO BENEFITS UNDER THE FLORIDA PERSONAL INJURY PROTECTION LAW, PLEASE COMPLETE THIS FORM AND RETURN IT PROMPTLY.

_____ _____ _____
YOUR NAME HOME PHONE BUSINESS PHONE

_____ _____ _____
YOUR ADDRESS (NO, STREET, CITY, STATE, ZIP CODE) DATE OF BIRTH SOCIAL SECURITY NO

_____ _____
PERMANENT ADDRESS, IF DIFFERENT HOW LONG HAVE YOU LIVED IN FLORIDA?

_____ _____
DATE AND TIME OF ACCIDENT AM/PM PLACE OF ACCIDENT (STREET, CITY OR TOWN, STATE)

BRIEF DESRIPTION OF ACCIDENT AND VEHICLES INVOLVED: _____
_____
_____

_____ _____
DESCRIBE MOTOR VEHICLE YOU OWN DESCRIBE MOTOR VEHICLE FAMILY MEMBER OWNS

AS A RESULT OF THIS ACCIDENT, WERE YOU INJURED? ___ YES ___ NO IF YOUR ANSWER IS YES, COMPLETE THE REST OF THIS FORM. IF NO, SIGN HERE AND RETURN THIS FORM TO US.

_____ _____
SIGNATURE DATE

DESCRIBE YOUR INJURY: _____
_____

WERE YOU TREATED BY A DOCTOR? ___ YES ___ NO IF IN HOSPITAL: ___ IN PATIENT ___ OUT PATIENT
DOCTOR'S NAME & ADDRESS: _____ HOSPITAL NAME & ADDRESS: _____
_____ _____

AMOUNT OF MEDICAL BILLS TO DATE: _____ WILL YOU HAVE MORE MEDICAL EXPENSE? ___ YES ___ NO
AT THE TIME OF YOUR ACCIDENT, WERE YOU IN THE COURSE OF EMPLOYMENT? ___ YES ___ NO
DID YOU LOSE WAGES OR SALARY AS A RESULT OF INJURY? ___YES ___NO AMOUNT LOST TO DATE $_____
WHAT IS YOUR AVERAGE WEEKLY WAGE OR SALARY $_____
IF YOU LOST WAGES, DATE DISABILITY BEGAN: _____ DATE YOU RETURNED TO WORK: _____
HAVE YOU RECEIVED, OR ARE YOU ELIGIBLE FOR, PAYMENTS UNDER ANY WORKER'S COMPENSATION OR UNEMPLOYMENT LAW? ___ YES ___ NO IF YES, AMOUNT $_____ PER WEEK / MONTH
NAMES & ADDRESSES OF PRESENT EMPLOYER(S) & YOUR OCCUPATION & DATES OF EMPLOYMENT FOR EACH:

EMPLOYER AND ADDRESS	YOUR OCCUPATION	FROM	TO
EMPLOYER AND ADDRESS	YOUR OCCUPATION	FROM	TO
EMPLOYER AND ADDRESS	YOUR OCCUPATION	FROM	TO

AS A RESULT OF INJURY, HAVE YOU HAD ANY OTHER EXPENSES? ___ YES ___ NO IF YES, EXPLAIN ON REVERSE
Any person who knowingly and with intent to injure, defraud, or deceive any insurance company files a statement of claim containing false, incomplete or misleading information is guilty of a felony of third degree.

I HEREBY AUTHORIZE RELEASE OF MEDICAL INFORMATION INCLUDING, BUT NOT LIMITED TO, MEDICAL BILLS AND REPORTS TO SUCH PERSONS AS THE COMPANY MAY DEEM NECESSARY TO PERFECT ITS RIGHTS OF RECOVERY UNDER THE "NO-FAULT" AUTO INSURANCE LAW.

SIGNATURE: _____ DATE: _____