INFORMACION BASICA DEL PACIENTE

PIP **Fecha: _____**

Apellido:	**Nombre:**			**MI:**
Direccion:		**Ciudad:**	**Estado:**	**Codigo postal:**
Telefono de casa:	**Telefono del trabajo:**			**Numero Seguro Social:**
Fecha de Nacimiento:	**Fecha del accidente o lesion:**			
Mano dominante: **____ Derecha ____ Izquierda ____ Ambas**				
Empleador:	**Oficio:**	**Correo electronico:**		

Nota especial: Si usted sufrio un accidente automovilistico, pase a la pagina siguiente.

Si no es un accidente automovilistico, por favor conteste las preguntas de abajo.

1. **Descripcion del accidente / lesion / aparicion de los sintomas**

   Entre la descripcion completa del accidente, el trauma o como aparecieron los sintomas en el espacio de abajo.

2. **Detalles durante y despues del accidente**

   Escribe los detalles de su condicion durante y despues del accidente y cuando aparecieron los sintomas.

Descripcion del Accidente Automovilistico

Conteste las preguntas de abajo. Si no sabe la respuesta, no conteste esa pregunta.

1. Clase de vehiculo

☐ Carro ☐ Station Wagon
☐ Van ☐ Pickup truck
☐ Camion grande ☐ Bus
Otro _____

2. Su posicion en el vehiculo

☐ Chofer ☐ Pasajero adelante
☐ Pasajero atras (lado izquierdo)
☐ Pasajero atras (lado derecho)
Otro _____

3. Que estaba haciendo su carro en el momento del accidente?

☐ Parado en interseccion ☐ Parado en trafico ☐ Parado en la luz
☐ Doblando a la derecha ☐ Doblando a la izquierda ☐ Parqueado
☐ En movimiento ☐ Disminuyendo velocidad ☐ Acelerando
Otro _____

4. Hora / Velocidad /Dano

Hora del accidente _____
Velocidad de su Vehiculo: _____ mph
Velocidad del otro Vehiculo: _____ mph
Dano de su vehiculo
☐ Minimo ☐ Moderado
☐ Total

5. Detalles del Accidente

Visibilidad en el sitio del accidente
☐ Pobre ☐ Aceptable ☐ Buena
Quien golpeo a Quien / Que?
☐ Usted golpeo al otro vehiculo
☐ El otro vehiculo lo golpeo
☐ **Usted golpeo…(objeto)**
_____

6. Condiciones de la carretera

Condiciones de la via al momento del accidente estaban:

☐ Congelada ☐ Mojada ☐ Arenosa ☐ Oscura ☐ Limpia y seca

Sitio de impacto
☐ De frente ☐ Adelante a la izquierda ☐ Adelante a la derecha
☐ Atras (bumper) ☐ Atras a la izquierda ☐ Atras a la derecha

7. Posicion de su cuerpo, etc.

Se dio cuenta del accidente? **Si** ☐ **No** ☐
Se preparo para el impacto? **Si** ☐ **No** ☐
Tenia puesto el cinturon ? **Si** ☐ **No** ☐
Tenia puesto el cinturon del hombro? **Si** ☐ **No** ☐

Su vehiculo tiene recostador de cabeza? **Si** ☐ **No** ☐
Cual era la posicion de su cabezera al momento del impacto?
☐ Nivel alto de cabeza ☐ Nivel bajo de cabeza ☐ Mitad del cuello
En que posicion estaba su cabeza al momento del impacto?
☐ Mirando al frente ☐ Volteada derecha ☐ Volteada a la izquierda

Se activaron las **bolsas de seguridad** en el lado del chofer? __ si __ no En el lado del pasajero __ si __ no Las laterales __ si __ no

8. Informacion adicional del accidente

En el caso de un accidente automovilistico, escriba cualquier informacion adicional que cree importante y que no fue cubierta arriba

9. Durante el accidente:

Su cuerpo golpeo el interior de su vehiculo? **Si** ☐ **No** ☐
repuesta fue **SI,** describa: _____
Perdio el conocimiento en el accidente **Si** ☐ **No** ☐
Si respuesta fue **SI**, por cuanto tiempo? _____
Dano estimado del vehiculo en dolares? _____
Dano de su vehiculo: ☐ Minimo ☐ Moderado ☐ Total
Se presento la policia en el lugar? **Si** ☐ **No** ☐
La policia hizo un reporte del accidente? **Si** ☐ **No** ☐

10. Despues del accidente:

Marque los sintomas que experimento despues del accidente

Dolor cabeza	Mareo	Dolor de espalda	Manos frias
Dolor cuello	Nausea	Dolor de cintura	Pies frios
Rigidez cuello	Confusion	Nerviosismo	Diarrea
Desmayo	Fatiga	Perdida del sabor	Depresion
Ruido oidos	Tension	Dedos de los pies adormecidos	Ansiedad
Perdida de olfato	Irritabilidad	Estrenimiento	Dolor de pecho
Dolor de ojos	Dificultad al respirar	Dificultad al dormir	

Otros: _____

11. Hospital /Sala de Emergencia

A donde fue despues del accidente?
☐ Casa ☐ Trabajo ☐ Emergencia ☐ Medico particular
Como llego alli? ☐ Uste mismo manejo ☐ Otra persona
☐ Ambulancia ☐ Policia
Tomaron X-Rays? Si ☐ No ☐ Examen sangre? Si ☐ No☐
Areas del cuerpo radiografiadas _____
Que examen de sangre? _____
Las Radiografias mostraron: _____
Tratamientos: ☐ Cuellera ☐ Hielo ☐ Otro: _____
Medicamentos: _____
Que intrucciones le dieron? _____

12. Tratamiento:

Que doctores lo vieron por este accidente antes de venir a esta oficina:
1. Dr. _____ Fecha 1ra visita ___/___/___
Especialidad: _____ Radiografias? **Si** ☐ **No** ☐
Tratamiento recibido: _____
Cuantos tratamientos recibio?_____ Esta en tratamiento todavia? **Si** ☐ **No** ☐
Mejoro con el tratamiento? _____Fecha de ultima visita:_____
Otro doctores que tambien lo vieron antes de venir a esta oficina?
2. Dr. _____ Fecha 1ra visita ___/___/___
Especialidad: _____ Radiografias? **Si** ☐ **No** ☐
Tratamiento recibido: _____
Cuantos tratamientos recibio?_____ Esta en tratamiento todavia? **Si** ☐ **No** ☐
Mejoro con el tratamiento? _____Fecha de ultima visita:_____

HISTORIAL MEDICO

EN ALGUNA VEZ HA ESTADO USTED EN UN ACCIDENTE DE AUTO O SE HA LASTIMADO EN SU TRABAJO? _____ Si _____ No Si contesto que si, anote la fecha y detalles de su accidente:

_____

ANTES DE LA CONDICION PRESENTE, EN ALGUN MOMENTO SE HA LASTIMAO EN LAS PARTES NOTADAS: ____Si ___No Fechas y detalles:_____

_____

SI HA SUFRIDO FRACTURAS O ROTURAS DE HUESOS ANOTE LAS FECHAS Y DETALLES:

_____

PREVIAS CIRUGIAS / OPERACIONES: _____

O ENFERMEDADES DE CUAL USTED PADECE EN ESTE MOMENTO: _____

_____

DESDE QUE COMENZO SU CONDICION HA TENIDO DIFICULTAD CON SU FUNCCION DE: _____ORINA _____INTESTINOS ____DAR DE CUERPO ____ SEXUAL

EXPLIQUE:_____

MEDICINAS QUE USTED TOMA: _____

DISFRUTABA DE BUENA SALUD ANTES DE ESTA CONDICION: ____ Si ____ No

SI CONTESTO NO, DE QUE PADECIA: _____

_____

MUJERES: ESTAS O PUDIERAS ESTAR EMBARAZADA? Si No Fecha el Ultimo Periodo _____

DOCTOR DE CABEZERA Y DIRECCION	**DOCTORES (DE AUTO O WORKERS COMP)**

HISTORIA SOCIAL

ESTADO MATRIMONIAL: ___CASADO ___SOLTERO ___VIUDO ___DIVOR (HIJOS_____)

USTED USA: ____ MEDICINA RECETADA ____CIGARRILLOS ____ALCOHOL ____ DROGAS

HISTORIA DE TRABAJO

TENIA USTED TRABAJO CUANDO COMENSO SU CONDICION? _____ Si _____No

HAS DEJADO DE TRABAJAR POR CULPA DE SU CONDICION? _____ Si _____ No

SU TRABAJO LE HACE PEOR SU CONDICION? _____ Si _____ No Explique:

_____

Yo autorizo que se le mande mis resultados y expediente medico a mis doctores nombrados en esta planilla. Yo doy autorizacion a Dr. Wanda Moreno y el personal de Brandon Chiropractic and Massage para recibir tratamiento por mi condicion medica.

Yo verifico que la informacion en este documento es verdadera y exacta acerca de mi condicion medica.

_____ FIRMA _____FECHA

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 INTEGRATED HEALTHCARE 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 dba 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

NON-PREGNANCY VERIFICATION FORM

I hereby notify all concerned that I neither, suspect or know positively at this time that I may be or am pregnant. I release this office from any and all damages arising from any and all procedures of a diagnostic or treatment nature with reference to the possibility of pregnancy.

_____ _____

Print patient's name Patient's signature

_____

Date

FORMA DE VERIFICACION DE NO ESTAR EMBARAZADA

Yo por este medio notifico a todos concernidos que yo ni conozco ni sospecho positivamente en este momento si estoy o pueda estar embarazada. Yo alivio a esta oficina de cualquier y todo daño derivando de cualquier y todo procedimiento de un diagnostico o tratamiento o similar con referencia a a posibilidad de embarazo.

_____ _____

Nombre escrito del Paciente Firma del Paciente

_____

Fecha

Brandon Chiropractic and Massage

654 E. Bloomingdale Ave., Brandon, FL 33511

CONSENT TO TREAT A MINOR

PATIENT NAME _____

GUARDIAN NAME _____

I HEREBY AUTHORIZE DR. MORENO TO ADMINISTER TREATMENT AS HE DEEMS NECESSARY TO MY SON / DAUGHTER NAMED ABOVE.

_____ _____

GUARDIAN SIGNATURE DATE

CONSENTIMIENTO PARA TRATAR A UN MENOR

NOMBRE DEL PACIENTE _____

NOMBRE DEL GUARDIAN _____

YO, POR ESTE MEDIO, AUTORIZO A LA DRA. MORENO A ADMINISTRAR TRATAMIENTO COMO LO CREA NECESARIO A MI HIJO / HIJA NOMBRADO ARRIBA.

_____ _____

FIRMA DEL GUARDIAN FECHA

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 two years. 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 Integrated Healthcare 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: _____

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.

_____ _____

Print patient's name Date

_____ _____

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

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RECONOCIMIENTO DEL RECIBO DEL AVISO DE LAS NORMAS DE PRIVACIDAD

Yo reconozco que fui provisto con una copia del Aviso de Las Normas de Privacidad y que las he leido o he declinado la oportunidad de leerlas y entiendo el Aviso de Las Normas de Privacidad. Entiendo que esta confirmación de reconocimiento será guardada en mi carpeta pacientil y mantenido por seis años.

_____ _____

Nombre escrito del Paciente Fecha

_____ _____

Padre, Guardian o Representativo legal del Paciente Firma del Paciente

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

ESTA CONFIRMACION DE RECONOCIMIENTO SERÁ GUARDADA EN LA CARPETA MEDICA DEL PACIENTE Y MANTENIDA POR SEIS ANOS.