

# PATIENT DATA SHEET

## GENERAL INFORMATION

\_\_\_\_/\_\_\_\_/\_\_\_\_  
DATE

\_\_\_\_\_  
LAST NAME FIRST NAME MIDDLE INITIAL

\_\_\_\_\_  
ADDRESS CITY STATE ZIP CODE

( ) \_\_\_\_\_ ( ) \_\_\_\_\_ ( ) \_\_\_\_\_  
HOME PHONE WORK PHONE CELL PHONE

\_\_\_\_\_  
EMAIL ADDRESS

**SEX** MALE FEMALE  
(PLEASE CIRCLE)

**MARITAL STATUS** SINGLE LEGALLY SEPARATED MARRIED WIDOWED DIVORCED  
(PLEASE CIRCLE)

\_\_\_\_/\_\_\_\_/\_\_\_\_ - \_\_\_\_-\_\_\_\_-\_\_\_\_  
BIRTHDATE SOCIAL SECURITY

\_\_\_\_\_  
REFERRED BY (EXAMPLE: DR, FRIEND, ETC - PLEASE NAME)

## EMPLOYER INFORMATION

**WORK STATUS** EMPLOYED FULL-TIME STUDENT PART-TIME STUDENT SELF-EMPLOYED  
(PLEASE CIRCLE) HOMEMAKER OTHER

\_\_\_\_\_  
OCCUPATION/ TYPE OF WORK

\_\_\_\_\_  
EMPLOYER

\_\_\_\_\_  
EMPLOYER ADDRESS CITY STATE ZIP CODE

\_\_\_\_\_  
EMPLOYER CONTACT PERSON ( ) PHONE

## CONDITION INFORMATION

**IS YOUR CURRENT COMPLAINT THE DIRECT RESULT OF:** WORK ACCIDENT YES NO \_\_\_\_/\_\_\_\_/\_\_\_\_  
(PLEASE CIRCLE) AUTO ACCIDENT YES NO ACCIDENT DATE

OTHER? (EXPLAIN) \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_





## Patient Financial Policy

Your understanding of our financial policies is an essential element of your care and treatment. If you have any questions, please discuss them with our front office staff or supervisor.

- As our patient, you are responsible for all authorizations/referrals needed to seek treatment in this office.
- Unless other arrangements have been made in advance by you, or your health insurance carrier, payment for office services are due at the time of service. We will accept VISA, MasterCard, Discover, American Express, cash or check, and CareCredit.
- Your insurance policy is a contract between you and your insurance company. **It is not our responsibility to keep track of your benefits or whether you are about to exhaust your benefits. Patients are expected to monitor this as they would their bank account.** As a courtesy, we will file your insurance claim for you if you assign the benefits to the doctor. In other words, you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within a reasonable period, we will have to look to you for payment.
- We have made prior arrangements with certain insurers and other health plans to accept an assignment of benefits. We will bill those plans with which we have an agreement and will only require you to pay the co-pay/co-insurance/deductible at the time of service.
- If you have insurance coverage with a plan with which we do not have a prior agreement, we will prepare and send the claim for you on an unassigned basis. This means your insurer will send the payment directly to you. Therefore, all charges for your care and treatment are due at the time of service.
- All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be "not covered," or you do not have an authorization, you will be responsible for the complete charge. We will attempt to verify benefits for some specialized services or referrals; however, you remain responsible for charges to any service rendered. Patients are encouraged to contact their plans for clarification of benefits prior to services rendered. We cannot be held accountable for any false or misinformation given to our office by you or your insurance carrier.
- You must inform the office of all insurance changes and authorization/referral requirements. In the event the office is not informed, you will be responsible for any charges denied.
- Past due accounts are subject to collection proceedings. All costs incurred including, but not limited to, collection fee, attorney fees and court fees shall be your responsibility in addition to the balance due this office.
- There is a service fee of \$25.00 for all returned checks plus our banks NSF Charge at the time. Your insurance company does not cover this fee.

**Signature of Patient/Responsible Party:** \_\_\_\_\_

Printed Name of Patient/Responsible Party: \_\_\_\_\_

Date: \_\_\_\_\_

Witness Signature: \_\_\_\_\_

Printed Name of Witness: \_\_\_\_\_

Date: \_\_\_\_\_

\_\_\_\_\_ Patient initials to indicate copy received.



# AUTO ACCIDENT HISTORY FORM

PATIENT NAME \_\_\_\_\_

DOB \_\_\_\_/\_\_\_\_/\_\_\_\_

ARE YOU CURRENTLY OFF WORK DUE TO THIS ACCIDENT  YES  NO

IF YES, PLEASE EXPLAIN \_\_\_\_\_

TYPE OF WORK  OFFICE/ CLERICAL  LIGHT LABOR  MODERATE LABOR  HEAVY LABOR

DO YOU HAVE ANY PREVIOUS WORK COMP INJURIES  YES  NO

IF YES, PLEASE EXPLAIN \_\_\_\_\_

DO YOU HAVE ANY PREVIOUS AUTO ACCIDENT INJURIES  YES  NO

IF YES, PLEASE EXPLAIN \_\_\_\_\_

DO YOU HAVE ANY PREVIOUS SPORTS OR OTHER INJURIES TO THE HEAD, NECK, OR BACK  YES  NO

IF YES, PLEASE EXPLAIN \_\_\_\_\_

WAS THE ACCIDENT ON-THE-JOB  YES  NO

YOU WERE  DRIVER  FRONT SEAT PASSENGER  REAR SEAT PASSENGER  
 MOTORCYCLE OPERATOR  MOTORCYCLE PASSENGER  OTHER \_\_\_\_\_

VEHICLE DRIVEN BY \_\_\_\_\_

YOUR VEHICLE - YEAR \_\_\_\_\_ MAKE \_\_\_\_\_ MODEL \_\_\_\_\_

YOUR ESTIMATED SPEED AT MOMENT OF ACCIDENT \_\_\_\_MPH  STOPPED  SLOWING  ACCELERATING

OTHER VEHICLE (IF APPLICABLE) YEAR \_\_\_\_\_ MAKE \_\_\_\_\_ MODEL \_\_\_\_\_

TIME OF DAY  DAYLIGHT  DAWN  DUSK  DARK

ROAD CONDITIONS  DRY  DAMP  WET  SNOW  ICE  OTHER \_\_\_\_\_

HEAD RESTRAINTS  NONE  INTEGRAL TYPE  ADJUSTABLE TYPE  UP  DOWN  DON'T KNOW

IF ADJUSTABLE, WAS THE POSITION ALTERED BY THE ACCIDENT  YES  NO

WAS THE SEAT BACK ADJUSTMENT ALTERED BY THE ACCIDENT  YES  NO

WAS THE SEAT BROKEN  YES  NO

LAP BELT  WEARING  NOT WEARING  DON'T KNOW

SHOULDER BELT  NONE  WEARING  NOT WEARING  DON'T KNOW

DID AIR BAG DEPLOY  YES  NO

IF YES, WERE YOU STRUCK  YES  NO

BODY POSITION  GOOD  FORWARD LEAN  OTHER \_\_\_\_\_

HEAD POSITION  FORWARD  LEFT  RIGHT  UP  DOWN

HANDS  ONE ON WHEEL  TWO ON WHEEL  N/A

BRAKES APPLIED  YES  NO

WERE YOU AWARE OF IMPENDING CRASH  YES  NO

