DAY	Date	Time
DOC:		Acct#
Conf: Yes No		Staff:

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AUTO ACCIDENT/PERSONAL INJURY INTAKE FORM

Full Legal Name: ______________________________ /___________________________________ /________
Last Name *First Name* *Middle Initial*

Age: ______ Date of Birth: _____ /______ /_____ S.S. #: ________-_______-_________

Address:______________________________________ City: ___________________ State: ___ Zip: ________

(H) Phone # (____)_____________ Mobile # (____)_________________ Best # to reach you ___ H or ___ M

E-mail address: ______________________________________ Gender: Female ___ (Pregnant? ___) Male ___

Single __ Married __ Other __ Spouse or Partner Name: ___________________________________

Employer / School: ____ Phone# (______)____________________

Address: _____________________________________ City: ___________________ State: ___ Zip: ________

Occupation: ____________________________ check which applies: (__Full time/ __Part time /__Student/ __Retired)

Emergency Contact
Name: _____________________________ Relationship: ____________ Phone#(_____)___________________

Other than yourself, to whom may we disclose your Protected Health Information?_______________________

Provide your PCP and current pharmacy information: (if no PCP, please put N/A in "Family MD" area)

Family MD ____ Phone # ______________________________

Pharmacy ____ Phone # ______________________________

How did you hear about us? (Please check all that applies) ☐ **TV** ☐ **Billboard** ☐ **Radio** ☐ **Internet** ☐ **OTHER__________**

If referred by our patient, please print their name(s):____

Is there any place you do NOT want us to leave a message? ________________________________

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PLEASE PROVIDE YOUR INSURANCE CARD(S) TO FRONT DESK FOR SCANNING/COPYING

HEALTH INSURANCE INFORMATION

Do you have medical insurance? Yes ___ No___	Do have any other insurance? Yes___ No___
Do you have Medicare? Yes ___ No___	If Yes, complete below;
Insurance Company Name __________________________	Insurance Company Name ________________________
Insurance Company Phone__________________________	Insurance Company Phone________________________
Type of Insurance: HMO PPO POS OTHER	Type of Insurance: HMO PPO POS OTHER
Policy#_________________ Group#________________	Policy#_________________ Group#_______________
Policy Holders Name _____________________________	Policy Holders Name ____________________________
Their DOB:____________ Relationship ______________	Their DOB:____________ Relationship _____________

What are the concerns for which you are seeking care today? (Primary concern first)

1. ____ **Date of onset:** _________________

2. ____ **Date of onset:** _________________

3. ____ **Date of onset:** _________________

4. ____ **Date of onset:** _________________

Medications and Supplements

What medications (prescribed or over the counter) are you currently taking? Including Vitamins?

_____________________________________ _____________________________________

_____________________________________ _____________________________________

_____________________________________ _____________________________________

_____________________________________ _____________________________________

_____________________________________ _____________________________________

_____________________________________ _____________________________________

Are you currently taking any of the following (please check all that apply): ☐ **asprin** ☐ **ibuprofen** ☐ **other** __________

Do you have any food or drug allergies; if so list them ____

The patient or legal guardian must sign authorizations, such as in the case of a minor or when the patient is physically or mentally incompetent to sign. If patient is able to sign by marking an X, legal guardian must witness signature.

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AUTO ACCIDENT/PERSONAL INJURY

Attention: If you were injured via an auto accident/personal injury, we ask that you provide Health Insurance information. We obtain this information as back up only, if for some reason, auto/personal injury info should deny your claim.

Was your injury (or injuries) related to: ☐ **auto accident** ☐ **personal injury**

Date of Injury: ____________________________

Where did accident occur: ____________________________________

How did accident occur, describe in your own words?____

____

____

Are you off work? ☐ **Yes** ☐ **No**

If yes, last day worked? ____/_____/_______

Who took you off work? ______________________________________ **When?** ____/____/_______

Who did you report this accident to? ____

Were you taken to the hospital: ☐ **Yes** ☐ **No**

If so, where? ____

How long were you hospitalized for? ____

If any, what other doctor(s) treated you since the accident: ____

Are you on any medications because of this accident? ☐ **Yes** ☐ **No**

If yes, describe: ____

How would you describe the pain you felt immediately following your injury?

☐ **Grabbing feeling** ☐ **sharp pain in one spot** ☐ **sharp pain with radiating symptoms**

☐ **Popping feeling** ☐ **dull ache** ☐ **other** _________________________

Please describe your current symptoms: ____

____

Have you been treated by anyone for the injury or symptoms? ☐ **Yes** ☐ **No**

If yes, explain: ____

IF AUTO ACCIDENTS PLEASE ANSWER THE FOLLOWING:

At the time of accident, were you: ☐ driver ☐ front passenger ☐ back passenger

At the time of accident, were you: ☐ stopped ☐ slowing ☐ accelerating ☐ moving sideways ☐ moving in reverse

During first impact did another vehicle hit your vehicle ☐ Yes ☐ No

It is best described as: ☐ subcompact ☐ compact ☐ full size ☐ small truck ☐ full size truck ☐ motorcycle ☐ bus ☐ other ______________

Did your vehicle hit something first? ☐ Yes ☐ No

If your vehicle hit something, what was it? ☐ another vehicle ☐ guard rail ☐ tree ☐ embankment ☐ other ______________________

Your vehicles first impact area was:

☐ Front passenger side corner ☐ Rear right side corner ☐ Head on

☐ Front passenger side ☐ Rear right side bumper ☐ other ______________________

☐ Front bumper ☐ Rear left side corner

☐ Front driver side corner ☐ Rear left side bumper

The vehicle I was in had a second impact? ☐ Yes ☐ No

If yes, describe: ____

At the time of accident, your vehicle was moving at ☐ moderate speed ☐ stopped ☐ other ______________

At the time of accident, other vehicle was moving at ☐ moderate speed ☐ stopped ☐ other ______________

Were you wearing a seat belt? ☐ Yes ☐ No

Was it also a shoulder belt? ☐ Yes ☐ No

Did the airbag deploy? ☐ Yes ☐ No

Did you hit your head w/ the steering wheel? ☐ Yes ☐ No

Were you expecting the impact? ☐ Yes ☐ No

Did you brace yourself? ☐ Yes ☐ No

Were you caught completely by surprise? ☐ Yes ☐ No

Were you looking right? ☐ Yes ☐ No

Were you looking left? ☐ Yes ☐ No

Were you looking straight ahead? ☐ Yes ☐ No

Were you looking back? ☐ Yes ☐ No

Did you hit the inside of the vehicle w/ another body part? ☐ Yes ☐ No

Describe: ____

If injury occurred differently than anything mentioned above, please describe: ______________________________

____

IF PERSONAL INJURY PLEASE ANSWER THE FOLLOWING:

My injury occurred when I ☐ was carrying object ☐ lifted an object ☐ sneezed ☐ coughed

☐ twisted at waist ☐ slipped & fell ☐ was looking over shoulder

☐ straightened up from bending

If you fell, choose all that apply ☐ surface was wet ☐ surface was icy ☐ surface has liquid on it

☐ Rug/carpet was uneven ☐ tripped over object on floor

☐ Other ____

If injury occurred differently than anything mentioned above, please describe: ______________________________

____

AUTO/PERSONAL INSURANCE INFORMATION

Carrier Name: ____

Address: ____

Telephone # ______________________________________

Claim # ____

CAR INSURANCE MED PAY EXPENSE (PLEASE CHECK)

☐ $5,000 ☐ $10,000 ☐ More $ _____________

How much has been used $ ___________________ How much is left ____________________

ATTORNEY INFORMATION

Have you obtained an attorney? ☐ **Yes** ☐ **No**

If yes, Name: ____

Address: ____

Telephone # ____

During future visits at Allegheny Medical Integrated Medicine, you have available, a team of providers to assist you with your health care. Please mark those providers that you would be interested in seeing to help you reach all your health care needs.

☐ **Primary Care** ☐ **Family Care** ☐ **Internal Medicine** ☐ **Nutrition**

☐ **Physical Therapy** ☐ **Chiropractic** ☐ **Orthopedic- Assoc/Provider**

Please describe your current symptom(s) ____

Approximant date began ___________________________

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PAST HISTORY INFORMATION

Please check any of the following, if any apply to you, currently or in the past:

☐ Psychiatric Problems ☐ Poor Appetite

MEDICAL HISTORY

GENERAL

Headaches ☐
Neck pain/ stiffness ☐
Shoulder pain/ stiffness R ☐ L ☐
Arm/hand pain/ stiffness R ☐ L ☐
Hip pain/ stiffness R ☐ L ☐
Leg/ foot pain/ stiffness R ☐ L ☐
Upper back pain/ stiffness ☐
Lower back pain/ stiffness ☐
High Blood Pressure ☐
Diabetes ☐
TMJ (Jaw Problems) ☐
Stomach/Intestinal Problems ☐
Lung Problems ☐
Communicable Diseases ☐
Bloating ☐
Menstrual Problems ☐
Pregnancy ☐
Prostate Problems ☐
Chronic Pain Syndrome ☐
Memory Loss ☐
Bowel/Bladder Problems ☐
Chills ☐
Depression ☐

Dizziness ☐
Fainting ☐
Fever ☐
Forgetfulness ☐
Headaches ☐
Loss of Sleep ☐
Nervousness ☐
Numbness ☐
Sweats ☐

EYES, EARS, NOSE

Ear Discharge ☐
Earache ☐
Loss of Hearing ☐
Ringing in Ears ☐
Bleeding Gums ☐
Difficulty Swallowing ☐
Blurred Vision ☐
Double Vision ☐
Crossed Eyes ☐
Persistent Cough ☐
Hoarseness ☐
Hay Fever ☐
Nose Bleed ☐

Sinus Problems ☐
Vision Problems ☐

GASTROINTESTINAL

Constipation ☐
Diarrhea ☐
Excessive Hunger ☐
Excessive Thirst ☐
Gas ☐
Hemorrhoids ☐
Other info not listed ☐

____

____

____

Tobacco ☐ Yes ☐ No
How often? ____________________

Alcohol ☐ Yes ☐ No
How often? ____________________

Caffeinated Beverages? ☐ Yes ☐ No
How often? ____________________

Recreational Drugs? ☐ Yes ☐ No
If yes, please discuss with doctor.

Consent for Treatment

The signature below authorizes consent to have your picture taken for the sole purpose of **identification.** This material **will not be sold** or **distributed for any reason**.

The information I have provided is complete and true to the best of my knowledge. I authorize the doctors and staff of Allegheny Medical, P.C. to administer such procedures and treatment as deemed necessary, or as required by my employer. There is no written, verbal, or implied guaranteed cure on our part. Due to our commitment to quality healthcare, we strive to improve services to our patients and we ask your consent prior to rendering treatment or services.

Signature of Patient ________________________________ Date:_________________________

Signature of Guardian________________________________ Date:_________________________

Assignment of Benefits

I _______________________________ authorize Allegheny Medical, P.C. to be paid directly for services rendered. I accept responsibility for any service(s) that may not be covered by my health insurance, automobile insurance, or workers compensation carrier. I further authorize Allegheny Medical, P.C. to furnish information concerning my present illness or injury which may contact alcohol, drug, HIV or psychiatric related history to the insurer and health care providers involved in my care. I further direct the insurer to pay without equivocation directly to Allegheny Medical, P.C. any and all benefits due as a result of treatment and service(s) provided. I am aware that I am personally responsible for charges and/or balances not covered by my insurance carrier. I hereby state and agree that a photocopy of this document will be deemed as valid and bindings on all parties involved as the original copy.

Signature of Patient ________________________________ Date:_________________________

Signature of Guardian________________________________ Date:_________________________

Medicare Assignment of Benefits

In accordance with the Medicare Act, Section 1842 (I) this letter is to advise you that Medicare will only pay for services that it determines to be reasonable and necessary under Section 1862 (a) (II) (A) of the Medicare act. If Medicare determines that a particular service(s), although normally covered is not reasonable and necessary because the service(s) is maintenance in nature as defined by Medicare policy, Medicare will deny payment for those service(s). Medicare is likely to deny payment for service(s) that lack medical necessity. By my signature, I acknowledge notification by Allegheny Medical, P.C. If Medicare denies payment, I agree to be personally and fully responsible for payment.

Signature of Patient ________________________________ Date:_________________________

Signature of Guardian________________________________ Date:_________________________

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY

PRACTICES FOR PROTECTED HEALTH INFORMATION

□ I acknowledge that I have received and read "Notice of Privacy Practices" from Allegheny Medical, P.C.

________________ ____________________________ ____
DATE PRINT NAME OF PATIENT SIGNATURE OF PATIENT/PERSONAL RESPRESENTATIVE

□ I decline to read or accept a copy of the "Notice of Privacy Practices" from Allegheny Medical, P.C.

________________ ____________________________ ____
DATE PRINT NAME OF PATIENT SIGNATURE OF PATIENT/PERSONAL RESPRESENTATIVE

Missed Appointment and Cancellation Policy

Our goal is to provide quality individualized care in a timely manner to each of our patients.
No-shows, late arrivals, and cancellations inconvenience those individuals who need access to our care. We would like to review with you our policy regarding missed appointments.

CANCELLATION OF AN APPOINTMENT/ MISSED APPOINTMENT

Appointments are in high demand. If you need to reschedule an appointment for any reason we require 24 hour notice. This policy enables us to better utilize available appointments for patients in need of medical care. A cancellation is considered late when the appointment is cancelled without 24 hour advanced notice. We will charge a $75 missed appointment fee if we do not receive a 24 hour notice of cancellation. If a second appointment is missed we will charge the cost of services that would have been incurred at the time of the appointment.

LATE ARRIVALS

Patients arriving 10 minutes or later for an appointment will be asked to reschedule the appointment for another day. If possible, an attempt will be made to reschedule the same day in the next open appointment slot. This appointment may be brief in nature due to the need to work you in between other scheduled patients.

I have read and understand the Missed Appointment and Cancellation Policy of Allegheny Medical and I agree to its terms.

____ _________________________________

Patient Signature **Date**