



COMPLETE CARE. ONE PLACE.

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

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 you have Medicare? Yes ___ No ___ Insurance Company Name _____ Insurance Company Phone _____ Type of Insurance: HMO PPO POS OTHER Policy# _____ Group# _____ Policy Holders Name _____ Their DOB: _____ Relationship _____	<u>Do have any other insurance?</u> Yes ___ No ___ If Yes, complete below; Insurance Company Name _____ Insurance Company Phone _____ Type of Insurance: HMO PPO POS OTHER Policy# _____ Group# _____ Policy Holders Name _____ Their DOB: _____ Relationship _____
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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: _____



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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



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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 _____



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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	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	How often? _____	
Alcohol	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	How often? _____	
Caffeinated Beverages?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	How often? _____	
Recreational Drugs?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, please discuss with doctor.		



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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 REPRESENTATIVE

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 REPRESENTATIVE

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 shows 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 \$25 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 15 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