ALLEGHENY MEDICAL
COMPLETE CARE. ONE PLACE.
alleghenymedical.com

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

WORKERS COMPENSATION 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? _____

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

We keep this info, in case your worker's comp is denied, then your health insurance will be billed.

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 _____

Do have any other insurance? 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

Do you have any known contagious diseases at this time? Yes, (Explain)_____ or **No** ☐

Worker's Compensation Information

Was your injury work related? □**YES** □**NO**

Was it reported to your employer? □**YES** □**NO**

To Whom? _____ **Telephone #** _____ **Ext.**_____

Date of Injury: _____ **Where did injury occur?** _____

Explain in your own words how injury occurred:_____

_____

Are you currently off work? □**YES** □ **NO** **If yes, last day worked?** _____ / _____ / _____

Who took you off work _____ **When?** _____ / _____ / _____

Who did you report this accident to? _____

Did you go to the hospital? □**YES** □**NO** **If yes, where & when** _____

How long were you hospitalized for? _____

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:_____

Attention: Please circle the answers to the following questions relating to the work injury.

My injury occurred:

While I was carrying an object & lost my balance:	**YES NO**
While a falling object struck me:	**YES NO**
While I was driving on the job:	**YES NO**
While I was doing the same task over & over	**YES NO**
When I lifted something	**YES NO**

I suffered the injury while lifting □ from the floor □ from a surface over my head
□ from surface about waist height □ other _____

The object I lifted was?
□2-5 lbs □5-10 lbs □10-15 lbs □ 15-20 lbs □ 20-25 lbs □25-50 lbs □50 + lbs

When I was lifting, I □ had my back straight □ was bent at the waist
□ was twisted to the side □ other_____

I fell at work,
□ onto the surface I was walking on
□ from the surface 2-4'high
□ from a surface 4-6 'high
□ from a surface 6-8' high
□ from a surface 8 +' high
□ other_____

When I fell the □ surface was wet □ surface was icy
□ surface had liquid on it □ tripped over object
□ rug/carpet was uneven □ Other_____

When I fell,
I landed on my □ back □ knees □ left side
□ stomach □ rear end □ right side □ outstretched arm

I hit the left side
of my □ back □ head □ elbow □ tailbone □ foot □ knee
□ arm □ hand □ wrist □ shoulder □ ankle □ hip □leg

I hit the right side
of my □ back □ head □ elbow □ tailbone □ foot □ knee
□ arm □ hand □ wrist □ shoulder □ ankle □ hip □leg

My injury occurred when I

□ carried an object □slipped & fell □coughed □sneezed □twisted at waist
□ straightened up from bending position
□ straightened up from a sitting position
□ other_____

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

_____

Worker's Compensation Insurance Information

Carrier Name: _____

Address: _____

Telephone #_____

Claim #_____

Attorney Information

Have you obtained an attorney? □YES □ NO

If yes, Name: _____

Address: _____

Telephone # _____

NON WORK RELATED

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 ☐ Physical Therapy ☐ Chiropractic ☐ ALLERGY

Please describe your current NONWORK RELATED symptom(s) _____

Approximant date began _____.

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

_____

_____

PAST HISTORY INFORMATION

Please check any of the following, that applies to you, currently or in the past;

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 w/ 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 sate 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). In your case, Medicare is likely to deny payment for the service(s) for lack of medical necessity. By my signature, I acknowledge notification by Allegheny Medical, P.C. that in my case, Medicare is likely to deny payment for those service(s). If Medicare denies payment,I agree to be personally and fully responsible for payment.

Signature of Patient _____ Date:_____

Signature of Guardian_____ Date:_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

I acknowledge that I have received Allegheny Medical, P.C.'s notice of Privacy Practices (listed on wall in waiting room) for protected health information.

_____ _____ _____

DATE PRINT NAME OF PATIENT SIGNATURE OF PATIENT/PERSONAL RESPRESENTATIVE