



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.



COMPLETE CARE. ONE PLACE.

alleghenymedical.com

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 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



COMPLETE CARE. ONE PLACE.

alleghenymedical.com

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



COMPLETE CARE. ONE PLACE.

alleghenymedical.com

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?



COMPLETE CARE. ONE PLACE.

alleghenymedical.com

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
Arm/Hand pain/ stiffness
Hip pain/stiffness
Leg/Foot pain/ stiffness
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
Alcohol
Caffeinated Beverages
Recreational Drugs

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



COMPLETE CARE. ONE PLACE.

alleghenymedical.com

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 (l) 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) (1) (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 REPRESENTATIVE



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

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