

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 # (____) _____ (select one) 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: _____ circle 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? _____

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 select 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? _____

HEALTH INSURANCE INFORMATION:

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.

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 _____

PATIENT NAME:



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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: _____

PATIENT NAME:



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PLEASE SELECT THE FOLLOWING ANSWERS RELATING TO YOUR 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 _____

PATIENT NAME: _____



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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?

PATIENT NAME:



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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.

PATIENT NAME:



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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.

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: _____

PATIENT NAME:



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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) (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 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