Auto Accident Patient History

Name: _____ **Date: _____**

History of the Occurrence

Were you the (driver or passenger)? What type of vehicle were you in (car/truck/van/other)

Was it (Your or Someone else's) vehicle?

The vehicle: ☐ Hit another vehicle ☐ Was hit In the: ☐ Right ☐ Left ☐ Rear ☐ Front ☐ Side

Type of Accident: ☐ Head-on Collision ☐ Rear-end collision

☐ Broadside Collision ☐ Front Impact; rear-ended car in front

☐ Non-Collision _____

Symptoms From The Accident

Did you get bleeding cuts or bruises? Y or N

If Yes, what bleeding cuts did you get from this Accident? _____

_____

If Yes, what bruises did you get from this Accident? _____

_____

Please describe how you felt. PLEASE BE SPECIFIC.

Immediately after the accident _____

_____

Later that day night: _____

_____

The next day: _____

_____

Work Status History

Occupation or Job Title _____

Have you missed time from work? Y or N

If yes: Full Time off work _____ to _____

Returned to Modified work _____ to _____

Been unable to work since the accident

Acct #: _____

Notto Chiropractic Health Center
Patient Information

Name: _____

Preferred Name: _____

Address: _____

City: _____

State: _____ Zip: _____

Home Phone: (____) _____ - _____

Work Phone: (____) _____ - _____

Who Referred You? _____

In Case of Emergency: _____

Phone Number: _____

Sex: _____

Date of Birth: _____/_____/_____

SS#: _____

Employer: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Spouse's Information

Name: _____

Date of Birth: _____/_____/_____

Employer: _____

Reason For Visit: _____

_____

Previous Treatments For This Condition: _____

_____

Other Doctors Seen For This Condition: _____

_____

When Did Your Symptoms Begin? _____/_____/_____ ☐ Came On Gradually

Were You In An Accident? Yes _____ No _____ Date of Accident: _____/_____/_____

If Yes, Auto _____ Home _____ W/C _____

Describe the Accident: _____

_____

Do You Have An Attorney? Yes _____ No _____ Name: _____

Authorized Consent For Treatment of Minor

I, _____ being the parent or legal guardian of _____, have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

_____

Mother, Father, Other

In order to submit a claim for payment to us for services covered under your policy, we must have your authorization to release medical information to your insurance carrier.

I hereby authorize release of information necessary to file a claim with my insurance company and **ASSIGN BENEFITS OTHERWISE PAYABLE TO ME, TO THE DOCTOR, OR GROUP INDICATED ON THE CLAIM.**

A copy of this signature is as valid as the original.

I attest that the above information is accurate to the best of my ability.

_____

Patient Signature

OTHER TREATMENTS

Name _____ **Date** _____

FIRST DOCTOR OR CLINIC SEEN:

Did you seek medical help soon after the accident? Y or N

If yes, how did you get there? ☐ Someone else drove me ☐ Drove own car

☐ Ambulance ☐ Police

Were you Hospitalized? Y or N

Doctor/Hospital/Clinic Name: _____ Date of first visit: _____

Were you examined? Y or N

Were X-rays taken? Y or N

Were you given treatment? Y or N

As a result of the treatment are you ☐ the same ☐ improving ☐ getting better Date of last treatment? _____

SECOND DOCTOR OR CLINIC SEEN:

Doctor/Hospital/Clinic Name: _____ Date of first visit: _____

Were you examined? Y or N

Were X-rays taken? Y or N

Were you given treatment? Y or N

As a result of the treatment are you ☐ the same ☐ improving ☐ getting better Date of last treatment? _____

THIRD DOCTOR OR CLINIC SEEN:

Doctor/Hospital/Clinic Name: _____ Date of first visit: _____

Were you examined? Y or N

Were X-rays taken? Y or N

Were you given treatment? Y or N

As a result of the treatment are you ☐ the same ☐ improving ☐ getting better Date of last treatment? _____

PRIOR SIMILAR SYMPTOMS:

Did you have physical complaints before this accident or illness? Y or N

If Yes, please describe in detail _____

_____

PRIOR to this accident or illness, have you ever had symptoms similar to what you are currently experiencing? Y or N

If Yes, please explain _____

_____

Complaints

Name _____ Date _____

A	NECK OR CERVICAL SPINE	NONE	MILD	MODERATE	SEVERE
A	Neck Pain and Soreness	A	B	C	D
B	Loss or Pain upon Movement	A	B	C	D
C	Shoulder Pain	A	B	C	D
D	Pain/Numbness/Tingling into arm or hand	A	B	C	D
E	Weakness in arm or hand	A	B	C	D
B	**MID-BACK OR THORACIC SPINE**	**NONE**	**MILD**	**MODERATE**	**SEVERE**
A	Mid-back Pain	A	B	C	D
B	Rib or Chest Pain	A	B	C	D
C	**LOWER BACK OR LUMBAR SPINE**	**NONE**	**MILD**	**MODERATE**	**SEVERE**
A	Lower Back Pain or Soreness	A	B	C	D
B	Loss or Pain with Movement	A	B	C	D
C	Pain into Hips or Buttocks	A	B	C	D
D	Pain into Legs, Knees, or Feet	A	B	C	D
E	Numbness/Burning in Legs or Feet	A	B	C	D
D	**OTHER COMPLAINTS:**	**NONE**	**MILD**	**MODERATE**	**SEVERE**
A	Headaches	A	B	C	D
B	Visual Disturbances/ Blurry Vision	A	B	C	D
C	Ringing or Buzzing in Ears	A	B	C	D
D	Nausea or Vomiting	A	B	C	D
E	Difficulty Breathing	A	B	C	D
F	Dizziness	A	B	C	D
G	Recent Weight Loss	A	B	C	D
H	Bowel or Bladder Dysfunction	A	B	C	D
E	**AGGRAVATED BY:**	**NONE**	**MILD**	**MODERATE**	**SEVERE**
A	Coughing	A	B	C	D
B	Sneezing	A	B	C	D
C	Prolonged Sitting	A	B	C	D
D	Prolonged Standing	A	B	C	D
E	Prolonged Riding in a Car	A	B	C	D
F	Lying on Stomach	A	B	C	D

Activities of Daily Living

Oswestry Back Disability Index

Name: _____ Date: _____

		No Pain	Slight Pain	Mild Pain	Moderate	Severe Pain	Very Severe
A	Pain Intensity	A	B	C	D	E	F
B	Personal Care	A	B	C	D	E	F
C	Lifting	A	B	C	D	E	F
D	Walking	A	B	C	D	E	F
E	Sitting	A	B	C	D	E	F
F	Standing	A	B	C	D	E	F
G	Sex Life	A	B	C	D	E	F
H	Social Life	A	B	C	D	E	F
I	Sleeping	A	B	C	D	E	F
J	Traveling	A	B	C	D	E	F

Name: _____ Date: _____

Please CIRCLE any of the following diseases you may have had:

Group 1	Group 2	Group 3	Group 4
A) Anemia	A) Diphtheria	A) Polio	A) Whooping Cough
B) Measles	B) Hypertension	B) Ulcer	B) Migraine Headache
C) Arthritis	C) Emphysema	C) Eczema	C) Gallbladder Disease
D) Smallpox	D) Chickenpox	D) Asthma	D) Tumor or Cancer
E) Pleurisy	E) Malaria	E) Colitis	E) Heart Disease
F) Stroke	F) Diabetes	F) Gout	F) Diverticulitis
G) Bursitis	G) Tuberculosis	G) Mumps	G) Rheumatic Fever
H) Pneumonia	H) Rheumatism	H) Hernia	H) Venereal Disease
I) Epilepsy	I) Osteoporosis	I) Typhoid Fever	I) Kidney Disease
J) Neuritis	J) Hypoglycemia	J) Scarlet Fever	J) Bowel Obstruction
K) Hay Fever	K) Encephalitis	K) Thyroid Disease	K) Alcoholism
L) Hepatitis	L) Meningitis	L) Shingles	L) Chemical Dependency

Other: _____

Are You Pregnant? Y N

Surgical History: Indicate the Year

A) Stomach _____	H) Thyroid _____
B) Rectum _____	I) Hernia _____
C) Tonsils _____	J) Uterus _____
D) Ovaries _____	K) Breast(s) _____
E) Gallbladder _____	L) Prostate _____
F) Appendix _____	M) Spinal _____
G) Colon _____	Other: _____

Please specify other: _____

Family Health History:

Father		**Mother**
Age: _____		Age: _____
Y N	Deceased	Y N
( )	Good Health	( )
( )	Heart Disease	( )
( )	Diabetes	( )
( )	Stroke	( )
( )	Cancer	( )
( )	Gout	( )

Additional Information:

_____

ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMNET TO DOCTOR PRIVATE AND GROUP ADDICENT HEALTH INSURANCE

Re: _____

Patient: _____

Employer: _____

Claim/Group: _____

Insured SS#/ID#: _____

I hereby instruct and direct the payment of all professionals or medical expense benefits allowable and otherwise payable to me under my current insurance policy to:

Dr. Leonard Notto, D.C.
619 East Parkway Drive
Russellville, AR 72801

as payment for professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

If my current policy prohibits direct payment to doctor, then I hereby also instruct and direct you to make out the check to me and mail it as follows:

C/O: Dr. Leonard Notto, D.C.
619 East Parkway Drive
Russellville, AR 72801

A photocopy of this ASSIGNMENT shall be considered as effective as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

Dated at _____ this _____ day of _____.

_____ _____

Insured Witness

Notice of Privacy Practices Acknowledgement
Notto Chiropractic Health Center

I understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or have been given the opportunity to receive a copy of the Notice of Privacy Practices. I also understand that this practice has the right to change its Notice of Privacy Practices and that I may contact the practice at any time to obtain a current copy of the Notice of Privacy Practices.

I authorize Notto Chiropractic Health to release my medical information to the following person(s):

Spouse: _____

Children: _____

Other: _____

None of the above: _____

_____
Patient Name or Legal Guardian (print)

_____
Date

_____

We have made the following attempt to obtain the patient's signature acknowledging receipt of the Notice of Privacy Practices:

Date _____ Attempt _____

Staff Name _____

Signatur

Name_____ DOB:_____ Date:_____

Financial Arrangements

We wish to make available as many options as possible for payment. So that you understand what we have available, on a standard basis, see below the explanation and choose best for you. We are, of course, most aware that extenuating circumstances which necessitate a payment schedule, which is tailored to a specific and unique situation. Please do not hesitate to ask for any such program. We believe that your health, the proper care and treatment you deserve are most important, and we are more than willing to make special arrangements which are feasible.

On the Job Injury-WC: I was injured at work, and this claim is being submitted under my employer's Workers Compensation insurance. In the event this claim should be rejected by that carrier, I understand that I am liable for payments on all treatments and services.
_____

Accident-PI: You have been involved in an accident in which someone else is responsible for your injuries. _____

*Because you have asked us to treat your injuries, you are responsible for payment of this service you receive from us. The person who caused your accident is responsible to you. Since you cannot legally transfer that responsibility to us for payment of your bills, we ask that you make arrangements for payment of your account. In some cases we will agree to defer payment until your case is settled with the person who caused your injuries if: you are personally injured sufficiently to cover your services and/or you obtain an approved attorney to represent you and protect payment of our services. _____

Self Pay: I will make payments in full at time of service. _____

_____

_____.

In the event of a default (which includes delinquencies and failure to make payments when due) any balance owing shall at the option of Dr Notto, become immediately due and payable. No further charges may be made on account in default status. If the defaulted amount is referred to collection or legal action I agree to pay reasonable court cost, attorney fees and any other cost of collection._____

Insurance: I herby authorize payment directly to Notto Chiropractic Health for professional services rendered. A photographic copy of this authorization is as valid as the original. I am responsible for any amount reduced or rejected by the insurance carrier, not paid within 90 days of submitted claim.

Primary Carrier: _____ Effective Date: _____

Deductible $ _____ Deductible Remaining $_____ Policy#_____

Co-Pay $ _____ Co-Insurance _____% Limitations:_____

Notes: _____

_____

Patient Signature_____ Date _____

NOTTO CHIROPRACTIC HEALTH CENTER
619 East Parkway Drive
Russellville, AR 72801

Electronic Health Records Intake Form

In compliance with requirements for the government EHR incentive program

First Name:_____ **Last Name**:_____

Email address: _____@_____

DOB: ___/___/_____ **Gender (Circle one):** Male / Female **Preferred Language:** _____

Preferred method of communication: Email/Phone/Mail

Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

Smoking Start Date (Optional): _____

CMS requires providers to report both race and ethnicity

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian) / Native Hawaiian or Pacific Islander / I Decline to Answer

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Are you currently taking any medications? (Please include regularly used over the counter medications)

Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Do you have any medication allergies?

Medication Name	Reaction	Onset Date	Additional Comments

☐ **I choose to decline receipt of my clinical summary after every visit.** (These summaries are often blank as a result of the nature and frequency of chiropractic care).

Patient Signature: _____ Date: _____

For office use only

Height: _____ Weight: _____ Blood Pressure: _____/_____ Pulse: _____