DEMOULIN CHIROPRACTIC CENTER, LLC

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PATIENT AUTO INJURY FORM

GENERAL INFORMATION

Patient Name:_____ Patient Sex: M F Date:_____

Date of Birth_____ Social Security #: _____ Height _____feet _____in Weight _____

Patient Address:_____ City:_____State:_____Zip:_____

Phone:_____ Referred for Treatment by:_____ Preferred Language _____

Auto Insurance Co. name: _____ Claim #:_____

Health Insurance name and ID #: _____

Attorney name and phone #: _____

RACE:

- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ African American
- ☐ Native Hawaiin/Pacific Islander
- ☐ Caucasian
- ☐ Not willing to provide

ETHNICITY:

- ☐ Hispanic/latino
- ☐ Non Hispanic/latino
- ☐ Not willing to provide

COMPLAINT HISTORY

Date of accident: _____ Were you the ( ) Driver ( ) Front passenger ( ) Back passenger ( ) Other _____

Was the vehicle hit in the ( ) front ( ) rear ( ) right side ( ) left side (rollover) Wearing seatbelt ( ) yes ( ) no

Did police come to the scene ( ) yes ( ) no Police report ( ) yes ( ) no

Did you go to the hospital ( ) yes ( ) no If yes, by ( ) ambulance ( ) car ( ) other _____

If yes, by when? ( ) from scene of accident ( ) same day ( ) next day ( ) after ____ days

Name of hospital: _____

Were you ( ) examined and ( ) discharged ( ) admitted ( ) x-rayed ( ) prescribed medication

Have you seen any other doctors for this accident ( ) yes ( ) no If yes, whom_____

_____

Medications? _____

Medication Allergies (if yes, what type)?_____

What is your physical activity at work?

- ☐ Mostly sitting
- ☐ Light manual labor
- ☐ Moderate manual Labor
- ☐ Heavy manual labor

Do you exercise?

- ☐ No regular exercise
- ☐ 1-2 times a week
- ☐ 3-4 times a week
- ☐ 5-7 times a week
- ☐ Cardiovascular
- ☐ Stretching
- ☐ Weight machine
- ☐ Free weights
- ☐ Sports _____ (Type)

PAST OR PRESENT SYMPTOMS, CONDITONS OR HABITS

- ☐ Swelling/stiffness of joint
- ☐ Headaches
- ☐ Dizziness
- ☐ Fainting spells
- ☐ Convulsions
- ☐ General prolonged fatigue
- ☐ Condition of uterus/ovaries
- ☐ High blood pressure
- ☐ Heart condition
- ☐ Respiratory condition
- ☐ Digestive problems
- ☐ Prostrate conditions
- ☐ Kidney/bladder problem
- ☐ Menstrual problems
- ☐ Breast soreness/lump
- ☐ Sinus conditions
- ☐ Allergies/asthma
- ☐ Cancer
- ☐ Stroke
- ☐ Excessive weight gain/loss
- ☐ Skin condition
- ☐ Arthritis
- ☐ Diabetes

Tobacco use:
☐ Past ☐ Present
☐ Occasional ☐ Moderate ☐ Heavy

Alcohol use:
☐ Past ☐ Present
☐ Occasional ☐ Moderate ☐ Heavy

Caffeine use: (coffee, tea, soft drinks)
☐ Past ☐ Present
☐ Occasional ☐ Moderate ☐ Heavy

Pregnancy: ☐ Past ☐ Present

Surgical Procedure: ☐ Past ☐ Present

Please list: _____

Comments:_____

_____

Major Accidents/Falls?_____

Any treatment for any health conditions in the past year?_____

Family History:_____

THE FOLLOWING IS OUR POLICY FOR PAYMENT OF MEDICAL SERVICES RENDERED:

1. You are responsible for the payment of any deductible and co-pay/ co-insurance at the time the services are rendered.
2. It is your responsibility to know the details concerning the coverage of your particular insurance plan, including if referral is required and to obtain and maintain referral authority.
3. As a courtesy, we will submit billing to your insurance company. If payment is not received within 60 days, it is your responsibility to intervene with your insurance company to get your bills paid. **PLEASE NOTE: YOU ARE ULTIMATELY RESPONSIBLE FOR PAYMENT OF SERVICES RENDERED**, regardless of insurance coverage, or the amount of payment made by the insurance company.
4. Any insurances checks received by you for services rendered here, must be endorsed and brought into this office immediately to be applied to your account.

MONTHLY STATEMENTS: All monthly statements are due and payable, in full, upon receipt, unless prior arrangements have been made with this office. If the bill remains unpaid for 30 days, and no satisfactory arrangements have been made, then collection proceedings may be instituted, without further warning. **Any and all costs associated with any collection proceedings, including reasonable attorneys' fees and costs will be added to the outstanding amount, and sall be your responsibility to pay.**

I HAVE READ AND UNDERSTOOD THE ABOVE:

SIGNATURE:_____ DATE:_____