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ATLANTIC CHIROPRACTIC ASSOCIATES, P.A.

Gentle, effective care for all ages

Auto Accident - New Patient Intake

Title: ☐ Dr. ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss **(check one) Gender**: ☐ Male ☐ Female **Date:** _____ /_____/_____

First Name: _____ Middle Initial: _____ Last Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: (_____) _____-_____ Work Phone: (_____) _____-_____

Cell Phone: (_____) _____-_____ Preferred contact method : ☐Cell Phone ☐Home Phone ☐Work Phone

Date of Birth: _____/_____/_____ Age: _____ Email:_____

Primary Doctor: _____ City:_____ State:_____

Race: (check one)
☐ White ☐ Black/African American ☐ American Indian/Alaska Native ☐ Other_____ ☐ I choose not to specify

Ethnicity: (check one) ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ I choose not to specify

Preferred Language: (check one)
☐ English ☐ Spanish ☐ Other _____ ☐ I choose not to specify

Marital Status: ☐ Single ☐ Married ☐ Other_____ Is your spouse a patient in the clinic? ☐Yes ☐ No

Spouse Data:
First Name: _____ Middle: _____ Last Name: _____

Home Phone: (_____) _____-_____ Cell Phone: (_____) _____-_____

Patient Employer Data:
Employment Status: ☐Employed ☐FT/☐PT ☐Student ☐FT/☐PT ☐Retired ☐Homemaker ☐Unemployed

Employer Name: _____

Address Line: _____ City: _____ State: _

Job Title/Position:_____

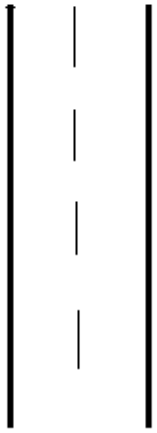
Emergency Contact:
Contact Name: _____ Relationship:_____

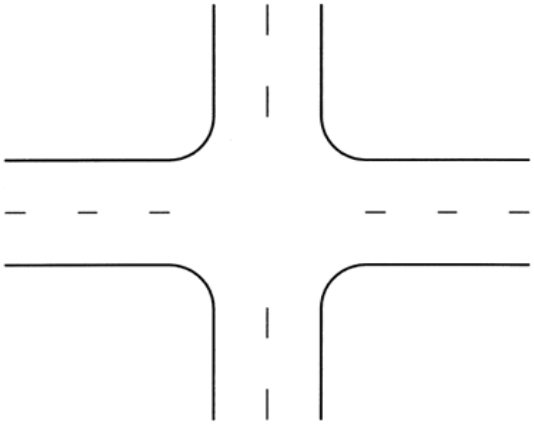
Phone:(_____)_____-_____

Date of Injury/Accident: _____ **Location(What state did it occur?)**_____
Do you have an attorney? ☐ Yes ☐ No If yes, who?_____
IN YOUR OWN WORDS, PLEASE DESCRIBE HOW THE ACCIDENT OCCURED:

_____
_____
_____
_____
_____
_____
_____

Please illustrate how the accident occurred using **one** of the diagrams:



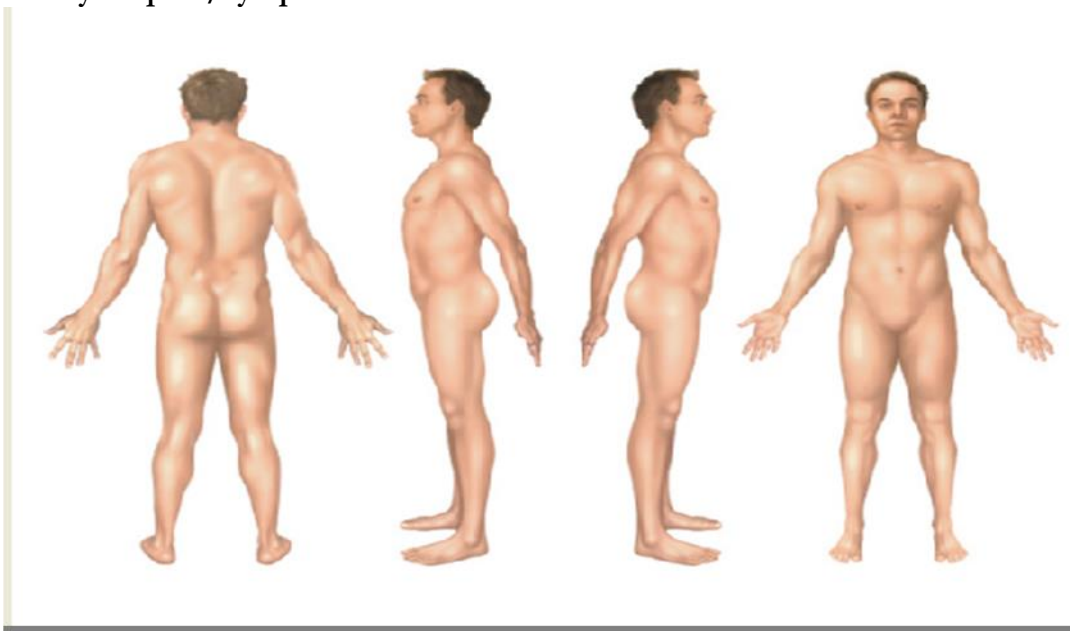


Point of Impact:

☐ Front ☐ Driver Front ☐ Passenger Front ☐ Rear
☐ Driver Side ☐ Passenger Side ☐ Passenger Rear ☐ Driver Rear

Current Complaints:

Please mark where your pain/symptoms are:



Patient Name:_____
Patient #:_____ **Date:**_____

Please grade your pain on a scale of 0-10:
[0= No Pain, 10= Extreme Pain]

Choose how frequent the pain is present:

Neck:	**0 1 2 3 4 5 6 7 8 9 10**	**Seldom - Intermittent - Frequent - Constant**
Upper/Mid Back:	**0 1 2 3 4 5 6 7 8 9 10**	**Seldom - Intermittent - Frequent - Constant**
Lower Back:	**0 1 2 3 4 5 6 7 8 9 10**	**Seldom - Intermittent - Frequent - Constant**
_____	**0 1 2 3 4 5 6 7 8 9 10**	**Seldom - Intermittent - Frequent - Constant**

Area(s) of complaint:
1. _____ 3. _____
2. _____ 4. _____

Circle which ones describe your symptoms:

- dull
- sharp
- throbbing
- burning
- deep
- aching
- tingling
- stabbing
- cramping
- numbness
- radiating
- stiffness

Other symptoms:_____

Can you go to sleep without problems? ☐ Yes ☐ No
Do you awaken because of pain? ☐ Yes ☐ No
If yes, where is the pain that wakes you up? _____

Injury History General:
Was the crash on-the-job? ☐ Yes ☐ No
You were: ☐ Driver ☐ Front Seat Passenger ☐ L – M – R Rear Seat Passenger ☐ Pedestrian
☐ Motorcycle Operator ☐ Motorcycle Passenger ☐ Other: _____
Vehicle Driven By: _____
Your Vehicle (year/make/model): _____
_____
Other Vehicle (year/make/model):_____
If Driver:
How many hands were on the wheel? : ☐ One on wheel ☐ Two on wheel ☐ None
Were the brakes applied? ☐ Yes ☐ No
Your Estimated Speed at Moment of Crash:
☐ Stopped
☐ Slow (Example: Parking Lot/Stop Light)
☐ Moderate (Example: Neighborhood)
☐ Fast (Example: Highway)
Time of Day: ☐ Daylight ☐ Dawn ☐ Dusk ☐ Dark
Road Conditions: ☐ Dry ☐ Damp ☐ Wet ☐ Snow ☐ Ice ☐ Other: _____
What was the position of the <u>top</u> of your headrest? :
☐ Middle of neck ☐ Middle of head ☐ None ☐ Even with the top of the head ☐ Even with the bottom of the head
If adjustable, did your headrest move due to the crash? ☐ Yes ☐ No ☐ Don't Remember
Did your seat move or change position? ☐ Yes: Base, Whole Seat, Seat Back ☐ No ☐ Don't Remember
Did your seat break? ☐ Yes ☐ No
Lap Belt: ☐ Wearing ☐ Not Wearing
Shoulder Belt: ☐ None ☐ Wearing ☐ Not Wearing ☐ Don't Know

Patient Name:_____
Patient #:_____ **Date:**_____

Did the airbag deploy? ☐ Yes ☐ No
If yes, were you struck by the air bag? ☐ Yes ☐ No What body part? _____
Did you strike anything in the vehicle? ☐ Yes ☐ No
If yes, what? ☐ Wheel ☐ Windshield ☐ Armrest ☐ Dashboard ☐ Side Window ☐ Airbag ☐ Side Door
Were you aware of impending crash? ☐ Yes ☐ No
Did you brace yourself for impact? ☐ Yes ☐ No
Direction of your head: ☐ Turned right ☐ Turned left ☐ Straight ahead ☐ Looking up ☐ Looking down
Did your head impact anything? ☐ Yes ☐ No ☐ Don't Know
Are you experiencing any? ☐ Mental Confusion ☐ Memory Loss ☐ Depression/Mood Swings ☐ Decrease Libido ☐ Distractibility ☐ Light Headedness
Other part of body injured? (Please list in order of severity.)
1. _____ 3. _____
2. _____ 4. _____
During the crash:
Did the vehicle strike any objects after crash? ☐ Yes ☐ No
If yes, please describe?
_____
_____
Were you dazed? ☐ Yes ☐ No
Did you lose consciousness? ☐ Yes ☐ No If yes, for how long? _____
Damage to your vehicle: ☐ Mild ☐ Moderate ☐ Extensive ☐ Totaled ☐ Unknown
Were police on the scene? ☐ Yes ☐ No If yes, report made? ☐ Yes ☐ No

After the crash:
Immediately after the accident, did you experience any of the following:
☐ Headaches ☐ Neck Pain ☐ Mid Back Pain ☐ Shoulder/Arm Pain
☐ Low Back Pain ☐ Hip/Leg Pain ☐ Dizziness ☐ Nausea
☐ Confusion ☐ Disorientation ☐ Other: _____
When did symptoms first appear? _____ (hours)
Where did you go after the crash? ☐ Work ☐ Hospital ☐ Home Other: _____

Emergency Department:
Hospital name: _____ DATE: _____
Mode of transportation:_____
Imaging / testing performed? ☐ Yes ☐ No
If yes, please list type (X-ray, MRI, CT, Lab work, EMG, etc.) location and date taken:
1._____ DATE: _____
2._____ DATE: _____
3._____ DATE: _____
Results: _____
_____
Medication prescribed:_____
Other treatments:_____
Follow-up instructions:_____

Self-assessed percent improvement as of today: (list for separate areas)
Area _____ % Improved: _____
Area _____ % Improved: _____
Area _____ % Improved: _____

Patient Name:_____
Patient #:_____ **Date:**_____

Any prior history of current complaints? ☐ Yes ☐ No
If yes, please describe episodes with dates:_____
_____
_____

Prior treatment by a chiropractor for these? ☐ Yes ☐ No If yes, please list who and when:
1._____
2._____

Circle the activities that aggravate your condition:

- sitting
- standing
- walking
- bending
- stooping
- lifting
- sleeping
- sneezing
- coughing
- straining
- reaching
- twisting
- looking up
- looking down
- movement
- rest
- lying face down
- driving
- typing
- scooping
- house chores
- exercise
- lying face up
- stair stepping

Other aggravating factors: _____

Circle activities that relieve your condition:

- sitting
- standing
- lying
- knees bent up
- support
- no movement
- movement
- heat
- ice
- topical gel
- ibuprofen
- medication
- rest
- stretching/exercising
- adjustments

Other relieving factors: _____

General Information:

Handedness: ☐ L ☐ R ☐ Both
Tobacco Use: ☐ Current Every Day Smoker ☐ Sometimes Smoker ☐ Former Smoker ☐ Never been a **Smoker** What is your level of interest in quitting smoking?
☐ 0 (No Interest) ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 (Very Interested)
Alcohol Use: ☐ None ☐ Social ☐ Moderate ☐ Heavy
Have you ever been disability rated? ☐ Yes ☐ No If yes, for what? _____

Treatment History:

Any prior Doctor seen for this condition? ☐ Yes ☐ No
1. **Doctor Name:** _____ Specialty: _____
Date seen: _____ Referred by: _____
Treatment type: _____
Currently treating? ☐ Yes ☐ No Did treatment help you? ☐ Yes ☐ No
Referred to another Provider? _____
Notes: _____

2. **Doctor Name:** _____ Specialty: _____
Date seen: _____ Referred by: _____
Treatment type: _____
Currently treating? ☐ Yes ☐ No Did treatment help you? ☐ Yes ☐ No
Referred to another Provider? _____
Notes: _____

Patient Name:_____
Patient #:_____ **Date:**_____

Current Medical History:

Current Health Problems (Heart Disease, Diabetes, High Blood Pressure, etc): ☐ None

_____

_____

_____

Current Medications Taken:

☐ Vitamins/Supplements ☐ None ☐ See Separate List

_____

_____

Are you currently pregnant? ☐ Yes ☐ No **If so, what is your due date?** _____

Have you had children? ☐ Yes ☐ No **If so, how many children have you had?** _____

List any known allergies you have to any medications: ☐ No known allergies

1. _____ 3. _____
2. _____ 4. _____

Has any doctor diagnosed you with High Blood Pressure? ☐ Yes ☐ No

Has any doctor diagnosed you with Diabetes presently? ☐ Yes ☐ No

If yes, what kind? ☐ Type 1 ☐ Type 2 If yes, was most recent hemoglobin A1c> 9.0%? ☐ Yes ☐ No ☐ Not Sure

If yes, other comments regarding Diabetes: _____

_____

Past Medical History:

Injuries to Head, Neck, or Back, including Motor Vehicle Accidents or Work Injuries:

_____

_____

Surgeries (Dates & Type): _____

_____

_____

Fractures (Dates & Type): _____

Family History: please circle and check all that applies

Diabetes	Yes	No	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Daughter	☐ Son
Heart Disease	Yes	No	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Daughter	☐ Son
High Cholesterol	Yes	No	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Daughter	☐ Son
Hypertension	Yes	No	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Daughter	☐ Son
Osteoporosis	Yes	No	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Daughter	☐ Son
Cancer (specify):_____	Yes	No	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Daughter	☐ Son
Psychological Disorders	Yes	No	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Daughter	☐ Son

☐ No known Conditions

Patient Signature:_____ **Date:**_____

To be performed by clinic staff: Height: _____ in Weight: _____ lbs BP:_____/_____ Pulse:_____bpm

Patient Name:_____

Patient #:_____ **Date:**_____

Verification Question: (chose only one question and provide the answer to the question selected)

☐What is the name of your favorite pet?
☐In what city were you born?
☐What high school did you attend?
☐What is your favorite movie?
☐What is your mother's maiden name?
☐What street did you grow up on?
☐What was the make of your first car?
☐When is your anniversary?
☐What is your favorite color?

Verification Answer to the chosen question: _____

Patient Signature:_____Date:_____

What is a verification question used for?
The verification question chosen above will be used to connect you to your Health Record using our patient portal.

How can I access this Patient Portal?
After your initial visit, we will enter this question you have selected as well as an email address that you have provided. You will then receive a registration email explaining how you can register. You must register for an account. This ensures that only you know your login credentials and helps to maintain the security of your data. If you do not receive a registration email please follow the simple steps below:
>Go to https://portal.fh-cloud.com
>On the login page, click the **Register Account** link below the **Sign In** Button.
>Complete the form. (Hint: Your email address is your username. Be sure to use the same email address that your provider has on file.)
>Click Sign Up
>Check your email for a Registration Code link. Click it to go to the Registration Validation page.
>Enter your password and click **Validate Registration**.

What is a Patient Portal?
Your patient portal is your link to information supplied by your healthcare provider. Here, you can download documents that your provider sends to you, exchange secure electronic messages with your provider, and download educational resources that your provider makes available to you.

How do I navigate through the portal?
Once you have successfully logged into the Patient Portal you will notice that everything is blank. On the left hand side you will find a tab that says **Manage**. Selecting this tab you will then need to select **Clinic Links.** You will then find our clinic listed. Once you hit **Approve** it will prompt you to enter the answer for the Verification Question you selected. After the clinic has been linked, you can now view documents under your **Dashboard** tab.

What if I forget my password?
Click the **Forgot Password** link on the login screen then enter your email address. Portal emails you a temporary password. Use it to login and reset your password.

If you have any further questions in regards to linking our clinic or how to download and view documents, we have sent please feel free to ask at your next appointment and we would be happy to assist.

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Authorization, Consent and Release

I consent and authorize the providers of Atlantic Chiropractic Associates, P.A. to examine and/or treat me / my child/legal dependent, if patient is a minor, today and during future office visits.

I authorize the release of any information, including the diagnosis and records of any treatment or examination rendered to me / my dependant during the period of such care to third party payers and/or other health practitioners.

I authorize and request my insurance company to pay benefits directly to Atlantic Chiropractic Associates, P.A., for the services rendered. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all co-pays, deductibles, and any other subscriber liabilities at the time that services are rendered, as are allowable.

_____ _____

Signature of Patient or Parent/Guardian of Minor Patient Date

Financial Policy

We are dedicated to providing you with the best possible care and service and regard your understanding of our financial policies as an essential element of your care and treatment. To assist you, we have the following financial policy. If you have any questions, please feel free to discuss them with our staff. Unless other arrangements have been made in advance by either yourself or your health coverage carrier, **full payment is due at the time of service.** For your convenience, most credit cards are accepted.

Your Insurance

We have made prior arrangements with many insurers and health care plans. We will bill those plans with whom we have an agreement and will collect any required co-payment at the time of service. The co-payment will be collected when you arrive for your appointment. In the event that your health coverage plan determines a service to be "not covered," **you will be responsible for the complete charge.** In that event, we will bill you and payment is due upon receipt of that statement.

If you have insurance coverage with a plan with which we do not participate, **payment is expected at the time that services are rendered**. We will provide you with a receipt from our office for you to submit to your insurance carrier. Your insurance company should then send the payment directly to you.

Missed Appointments

In order to provide the best possible service and availability to all our patients, there may be a $15.00 fee for any doctor appointment not canceled at least 24 hours in advance. Also, due to the scheduling of massage therapy, there may be a fee of 75% of our regular massage charges for appointments not canceled at least 24 hours in advance. Please call us as early as possible if you know you will need to reschedule your appointment. More than three (3) "no show" appointments without a valid reason may result in discharge from our practice.

I have read and understand the financial policy of the practice; and, I agree to be bound by its terms. I also understand and agree that such terms may be amended from time to time by the practice.

Acknowledgment of Privacy Practices

Our practice is committed to protecting privacy and confidentiality. With my consent, Atlantic Chiropractic Associates, P.A., may use and disclose Protected Health Information (PHI) about me or my dependant to perform treatment, payment and healthcare operations (TPO). Please refer to Notice of Privacy Practices of Atlantic Chiropractic Associates, P.A. for a complete description of such uses and disclosures. I acknowledge that a copy of said Notice of Privacy Practices was offered to me.

_____ _____

Signature of Patient or Parent/Guardian of Minor Patient Date

Patient Name:_____

Patient #:_____ **Date:**_____

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Record Release

I, _____/_____,
Patient Name Date of Birth

hereby request my records and/or imaging reports be released from:

_____
Organization

_____
Organization

_____
Organization

and to be faxed/mailed/taken to Atlantic Chiropractic Associates, P.A.

Patient/Guardian _____ Date _____

Witness _____ Date _____

Patient Name:_____

Patient #:_____ **Date:**_____