

PATIENT INFORMATION
INFORMACIÓN DEL PACIENTE

Name/Nombre _____

Address/Dirección _____

City/Ciudad _____ State/Estado _____ Zip/Código postal _____

Home Phone/Teléfono de casa _____ Cell phone/Teléfono móvil _____

Email/correo electrónico _____

Occupation/Ocupación _____ Employer/ Empleador _____

Employer address/Dirección del empleado _____

City/Ciudad _____ State/Estado _____ Zip/Código postal _____

Age/Edad _____ Date of birth/Fecha de nacimiento ___/___/___ Sex: ___ Male/ Masculino ___ Female/ Femenino

Spouse/Esposo(a) _____

Preferred method of contact: ___ Home phone ___ Cell phone ___ Text ___ Email

Método de contacto preferido: ___ Teléfono de la casa ___ Teléfono celular ___ Texto ___ Correo electrónico

How were you injured?/¿Cómo te lastimaste? ___ Auto accident/Accidente de auto

___ Work injury/ Lesión en el trabajo ___ Other/Otro _____

Do you have an attorney?/¿Tienes un abogado? ___ Yes/Si ___ No

Do you have car insurance?/¿Tiene seguro de automóvil? ___ Yes/Si ___ No

Please give us the following information ONLY IF YOU DON'T HAVE AN ATTORNEY
Por favor dénos la siguiente información SÓLO SI NO TIENE UN ABOGADO

Name of insurance company/ Nombre de la compañía de seguros _____

Date of injury/ Fecha de accidente _____

Claim number/ Numero de reclamo _____ Adjuster/ajustador _____

Person responsible for injury/ Persona responsable de la lesión _____

Name of your insurance company/ Nombre de su compañía de seguros _____

Policy number/ Número de póliza _____

Do you have a copy of a póllice report?/¿Tienes una copia de un informe policial? ___ Yes/Si ___ No

AUTHORIZATION & ASSIGNMENT OF BENEFITS

*Dr. Kenneth D. Pace, D.C., Dr. Kenneth D. Pace, D.C., LLC,
The Injury Center of Kenner*

I consent to all diagnostic procedures, chiropractic care, medical care, and other treatments deemed necessary by the providers listed above.

I authorize the release of any and all information from my medical records regarding my condition and my treatment to: my other physicians for purposes of treatment, my insurance company for purposes of submitting insurance claims, my attorney for use in pursuing any claims that I may have in connection with the conditions for which I am being treated, and any third party who has assumed responsibility for my bill for purposes of verification and payment. This release will expire sixty months after termination of my treatment. I may revoke this release in writing at any time.

I authorize the above listed providers to request and receive any and all records deemed necessary from my insurance company(s) or any third party who may hold records which may help properly administer care, or to properly maintain files or records pertaining to my care or treatment in this office, whether those records be medical, chiropractic, or insurance, and I further instruct any insurance company or other party who holds or controls any such records to release said records to you at your request.

I hereby authorize, request and assign direct payment of medical insurance benefits to any and all of the above listed providers for services rendered and, to the extent permitted by law, I name the above listed providers as the mandatary of any health insurance, reimbursement plan, or proceeds of any settlement, adjudication or verdict applicable to or arising out of any charges for services rendered in connection with their treatment of me, to the full extent of such charges. I authorize the provider to sign, endorse, and deposit such checks, notes or other form of payment into the providers account in recognition of money owed by me for services rendered. I understand that should one of the listed providers endorse a check payable to me or payable to the provider, that provider is authorized to apply these funds to pay any balance that I may have with the office and the provider will remit to me in a timely fashion any remaining funds.

In the event that any insurance company is obligated by contractual agreement to make payment to me or to you for the demand by you, I hereby assign and transfer to you the cause of action that exists in my favor against any such company, and authorize you to prosecute said action either in my name or your name as you see fit. I agree to pay for services rendered. I understand that whatever amount the listed providers do not collect from insurance proceeds (whether it be all or part of what is due) I personally owe you.

I understand that in the course of treatment I may be referred for x-rays or other diagnostic studies or therapeutic services to The Injury Center of Kenner and/or Dr. Kenneth D. Pace LLC, and that the fees for those services will be added to and billed with charges from this office. I further understand that Dr. Kenneth D. Pace, D.C. also owns an interest in The Injury Center of Kenner.

I understand and agree if my current policy or any third party responsible for payment fails to make a direct payment to the provider, I agree to immediately endorse and deliver such check(s) and forward it to the above provider (with such provider authorized to deposit these checks on my behalf) for the professional or medical expenses incurred, and otherwise payable to me. I UNDERSTAND THIS IS AN IRREVOCABLE AND DIRECT ASSIGNMENT OF BENEFITS.

I certify that all information given by me is true and correct.

A photocopy of this assignment shall be regarded as an original.

NAME

DATE

The Injury Center of Kenner
Acknowledgement of Privacy Practice Procedures
(Aviso de Prácticas de Privacidad)

Patient Acknowledgment (Reconocimiento de Paciente)

By signing my name below, I acknowledge that the Privacy Practice Procedures have been explained to me, and I understand that I may request a copy at any time. If you have any questions about our Privacy Practices please contact any staff member in this office.

Al firmar mi nombre abajo, reconozco que me han explicado los procedimientos de práctica de privacidad, y yo entiendo que puedo solicitar una copia en cualquier momento. Si usted tiene alguna pregunta sobre nuestras prácticas de privacidad, por favor contacte a un miembro del personal en esta oficina.

Patients name (Nombre de paciente): _____

Patients signature (Firma de paciente): _____

Date (Fecha): _____

If signed by someone other than the patient, please indicate (Si es firmado por alguien que no sea el paciente, indique): _____

Relationship (Relacion) Parent or guardian (Padre o guardián): _____

Guardian or conservator of an incompetent patient (Tutor o curador de un paciente incompetent)

Other (otro) Please specify (Por favor especifique) _____

Exceptions (Excepciones)

The Injury Center of Kenner may share my health information with the following individuals:
(puede compartir mi información de salud con las siguientes personas)

Name (nombre): _____ Initials(iniciales)

The Injury Center of Kenner may send a report to my attorney:
(puede enviar un informe a mi abogado(a):

Name (nombre): _____ Initials (iniciales)

The Injury Center of Kenner may send a report to my primary care physician:
(puede enviar un informe al médico de atención primaria)

Name (nombre) _____ Inintials (iniciales)

Office use only (Uso solamente de oficina)

We attempt to obtain written acknwoledgement of Privacy Procedures, but it could not be obtained because: (Se intentó obtener acknwoledgement por escrito de los procedimientos de privacidad, pero no se pudo obtener debido:

Individual refused to sign (Individual se negó a firmar) Witness (Testigo): _____

Date (Fecha): _____ Witness name Print(Testigo nombre) _____

ACCIDENT QUESTIONNAIRE
Cuestionario de Accidentes

DATE _____

NAME _____
 NOMBRE _____

Date of Accident _____
 Fecha del accidente _____

1. What kind of car were you in?
¿En qué tipo de coche estaba?

- Compact
- Compacto
- Mid-size
- De tamaño medio
- Full size
- El tamaño completo
- SUV
- SUV
- Mini-van
- Monovolumen
- Pick-Up Truck
- Camioneta
- Bus
- Autobús

2. What was the other vehicle?
¿Que tipo era el otro vehiculo ?

- Compact
- Compacto
- Mid-size
- De tamaño medio
- Full size
- El tamaño completo
- SUV
- SUV
- Mini-van
- Monovolumen
- Pick-Up Truck
- Camioneta
- Bus
- Autobús

3. Did you hit anything else after the first impact?

- Tuvo un Segundo impacto?**
 Yes/Si No
- Another vehicle
 Otro vehículo
- Other/Otro _____

4. At the time of the crash what was your vehicle doing?
En el momento del accidente lo que estaba haciendo su vehículo?

- Sitting at a stop sign/stop light
- Sentado en una señal de stop / luz de freno
- Stopped in traffic or stopped for another reason
- Detenido en el tráfico o interrumpido por cualquier otro motivo
- Moving with traffic
- Se mueve con el tráfico
- Crossing an intersection
- Cruzar una intersección
- Turning
- Torneado
- Other/Otro _____

5. How was your vehicle hit?
¿Donde recibio el impacto su vehiculo ?

- From behind/rear impact
- De atrás / impacto trasero
- From the front/front impact
- De la parte frontal / de impacto frontal
- From the side/side impact
- Impacto lateral
- Other/otro _____

6. What was the weather like when your crash happened?
¿Como estaba el clima cuando recibio el impacto ?

- Raining or recently rained
- Lloviendo o recientemente llovido
- Misting or recently misty
- Brumoso
- Dry
- Seco

7. What was the street condition?
¿Cuál era el estado de la calle ?

- Wet/slick
- Mojado / resbaloso
- Dry
- Seco

Name (nombre) _____ Date _____

8. Where were you in the car?

En que lugar se encontraba en el coche?

- Driver
Conductor
- Front seat passenger
Pasajero del asiento delantero
- Passenger in back seat on driver's side
Pasajeros en el asiento trasero del lado del conductor
- Passenger in back seat on passenger side
Pasajeros en el asiento trasero del lado del pasajero
- Passenger in back seat in the middle
Pasajeros en el asiento trasero en el medio
- Passenger in 3rd seat of SUV or mini-van
Pasajero en 3er asiento de SUV o mini -van
- Passenger in car-seat
Pasajero en el coche - asiento
- Passenger in booster seat
Pasajero en un asiento elevado

10. Were you hit by an airbag?

¿Fue golpeado por una bolsa de aire ?

Yes/Si No

If yes, where were you hit?

Si es así , ¿dónde fue golpeado ?

- Head/face/neck
Cabeza / cara / cuello
- Arm/forearm/shoulder
Brazo / antebrazo / hombro

12. Did you go to a hospital or doctor after the crash?

¿ Visito un hospital o medico despues del accidente ?

Yes/Si No

What hospital/doctor? _____

¿En qué hospital / médico ? _____

9. Were you wearing a seat belt?

¿Estaba usando un cinturón de seguridad ?

Yes/Si No

What kind of seat belt were you wearing?

¿Qué tipo de cinturón de seguridad estaba usando?

- Lap/Shoulder
Regazo / hombro
- Shoulder only
Sólo hombro
- Lap only
Sólo regazo

11. What was your body position?

¿En que posicion estaba ?

- Facing forward
Mirando hacia en frente
- Turned to right or left
De lado
- Leaning forward
Inclinandose hacia adelante
- Slouching in seat
Encorvado

13. What was your head position?

¿Cuál fue la posición de su cabeza ?

- Looking forward
Mirando hacia enfrente
- Head turned right, left, up or down
Doblada a la derecho, izquierda, arriba o abajo

DOCTOR'S USE ONLY - MÉDICO DE USAR SOLAMENTE

SYMPTOMS
SINTOMAS

DATE _____

NAME _____
 NOMBRE _____

Date of accident _____
 Fecha del accidente _____

INSTRUCTIONS: Check any symptom you have felt at any time since your car accident
INSTRUCCIONES : Comprobar cualquier síntoma que se han sentido en ningún momento desde su accidente de tráfico

1. CUTS OR BRUISES - Cortaduras y hematomas

- ___ Head or face
Cabeza o la cara
- ___ Neck
Cuello
- ___ Arms
Brazos
- ___ Legs
Piernas
- ___ Seat belt bruise or chest pain from seat belt
Hematoma por el cinturón de seguridad o dolor en el pecho del cinturón de seguridad
- ___ Other cuts or bruises
Otros cortes o contusiones

2. HEAD INJURIES - HERIDAS EN LA CABEZA

- | | |
|---|---|
| ___ Were you knocked out or unconscious?
Estaba inconsciente ? | ___ Trouble speaking
Dificultad para hablar |
| ___ Headaches
Dolor de cabeza | ___ Tired or fatigued
Cansancio o fatigado |
| ___ Dizziness
Mareo | ___ Appetite changed
Cambio en apetito |
| ___ Difficulty walking
Dificultad para caminar | ___ Sleeping more or less than usual
Duerme más o menos de lo usual |
| ___ Balance problems
Problemas de equilibrio | ___ Vision problems; blurry, double vision
Problemas de la vista; borrosa , visión doble |
| ___ Confused
Confusion | ___ Trouble reading or writing
Dificultad para leer o escribir |
| ___ Sensitive to noise
Sensible al ruido | ___ Nausea/Vomiting
Náuseas / vómitos |
| ___ Sensitive to light
Sensible a la luz | ___ Depressed or sad
Deprimido o triste |
| ___ Trouble concentrating
Dificultad para concentrarse | ___ Mood swings
Cambios de humor |
| ___ Trouble remembering
Problemas para recordar | ___ Angry or agitated
Enojado o agitado |

Name _____ Date _____

3. JAW PROBLEMS - MANDIBULA PROBLEMAS

- ___ Jaw pain
dolor en la mandíbula
- ___ Clicking
Al hacer clic
- ___ Pain while chewing
Dolor al masticar
- ___ Pain while talking
Dolor mientras se habla
- ___ Pain while yawning
Dolor al bostezar
- ___ Pain while moving jaw from side to side
Dolor mientras mueve la mandíbula de lado a lado

4. NECK/UPPER BACK - CUELLO / ESPALDA SUPERIOR

- ___ Neck pain ___ Right side ___ Left side ___ Both sides
Dolor de cuello ___ lado derecho ___ lado izquierdo ___ ambos lados
- ___ Upper back pain ___ Right side ___ Left side ___ Both sides
Dolor de espalda superior ___ lado derecho ___ lado izquierdo ___ ambos lados
- ___ Pain/tingling/numbness radiating into the RIGHT shoulder, arm, forearm or hand
Dolor / hormigueo / entumecimiento que irradia hacia el hombro derecho , brazo , antebrazo o la mano
- ___ Pain/tingling/numbness radiating into the LEFT shoulder, arm, forearm or hand
Dolor / hormigueo / entumecimiento que se irradia hacia el hombro izquierdo , brazo , antebrazo o la mano
- ___ Headaches at base of the skull
Dolores de cabeza en la base del cráneo
- ___ Popping/clicking in neck
estallo / clic en el cuello

5. MID-BACK/LOWER BACK PAIN - Media de la espalda / dolor de espalda baja

- ___ Mid-back pain ___ Right side ___ Left side ___ Both sides
Mitad de espalda ___ lado derecho ___ lado izquierdo ___ ambos lados
- ___ Low back pain ___ Right side ___ Left side ___ Both sides
Dolor de espalda baja ___ lado derecho ___ lado izquierdo ___ ambos lados
- ___ Pain/tingling/numbness into the RIGHT buttock, thigh, leg or foot
Dolor / hormigueo / entumecimiento que se irradia glúteo , muslo, pierna o el pie
- ___ Pain/tingling/numbness into the LEFT buttock, thigh, leg or foot
Dolor / hormigueo / entumecimiento que se irradia glúteo , muslo, pierna o el pie

6. OTHER AREAS OF PAIN - Otros áreas de dolor

- | | | | |
|----------------------|----------------------|-----------------------|--------------------------------|
| ___ Right shoulder | ___ Right wrist | ___ Right hip | ___ Right leg/ankle |
| ___ Hombro derecho | ___ Muñeca derecha | ___ Cadera derecha | ___ Pierna derecha / tobillo |
| ___ Left shoulder | ___ Left wrist | ___ Left hip | ___ Left leg/ankle |
| ___ Hombro izquierdo | ___ Muñeca izquierda | ___ Cadera izquierda | ___ Pierna izquierda / tobillo |
| ___ Right elbow | ___ Right hand | ___ Right knee | ___ Right foot |
| ___ Codo derecho | ___ Mano derecha | ___ Rodilla derecha | ___ Pie derecho |
| ___ Left elbow | ___ Left hand | ___ Left knee | ___ Left foot |
| ___ Codo izquierdo | ___ Mano izquierda | ___ Rodilla izquierda | ___ Pie izquierdo |