PATIENT INFORMATION

NAME:_____

HOME ADDRESS:_____CITY:_____STATE:_____ZIP:_____

HOME PHONE:_____CELL PHONE:_____OCCUPATION:_____

E-MAIL:_____EMPLOYER:_____

EMPLOYER ADDRESS:_____CITY:_____STATE:_____ZIP:_____

WORK PHONE:_____DATE OF BIRTH:____/____/_____SEX:___M ___F

SPOUSE:_____SPOUSE'S EMPLOYER:_____

EMPLOYER ADDRESS:_____CITY:_____STATE:___ZIP:_____

HOW DID YOU HEAR ABOUT OUR OFFICE?

Referred by Friend/Relative: Name_____ My Physician: Dr._____

Attorney_____

INSURANCE INFORMATION

TYPE OF INJURY: ___CAR ACCIDENT ___WORK INJURY ___SLIP AND FALL ___HOME INJURY

___OTHER:_____

DATE OF INJURY:_____TIME:_____WHERE DID IT HAPPEN:_____

HAVE YOU RETAINED AN ATTORNEY? ___YES ___NO NAME:_____

IF INJURED ON THE JOB, DID YOU NOTIFY SUPERVISOR? ___YES ___NO DATE:_____

IF INJURED ON THE JOB, WAS AN INJURY REPORT COMPLETED?___YES ___ NO DATE:_____

DO YOU HAVE HEALTH INSURANCE?___YES___NO NAME OF HEALTH INSURANCE_____

DO YOU HAVE MED PAY WITH YOUR CAR INSURANCE? ____YES____NO

YOUR CAR INSURANCE COMPANY NAME _____POLICY NUMBER_____

DO YOU HAVE UNINSURED MOTORIST COVERAGE?_____YES____NO

LIABILITY INFORMATION (PERSON WHO HIT YOU): CLAIM NUMBER_____

ADJUSTER'S NAME_____INSURANCE COMPANY_____

IT IS THE POLICY OF THIS OFFICE THAT WE FILE TO ALL AVAILABLE INSURANCE. BY SIGNING BELOW YOU UNDERSTAND AND AGREE WITH THIS POLICY AND WILL PROVIDE THIS OFFICE WITH ALL INSURANCE INFORMATION THAT IS NEEDED.

_____ DATE:_____

Patient or Representative's Signature

AUTHORIZATION & ASSIGNMENT OF BENEFITS

Dr. Kenneth D. Pace, D.C., Dr. Kenneth D. Pace, D.C., LLC,
Medical Rehab 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 Medical Rehab 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 Medical Rehab 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

Medical Rehab Accident Injury Center
Acknowledgement of Privacy Practice Procedures
(Acuse de Privacidad Procedimientos de Práctica)

Patient Acknowledgemte (Reconocimiento de Pacientes)

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 los procedimientos de práctica de privacidad se han explicado a mí, y yo entiendo que puedo solicitar una copia en cualquier momento. Si usted tiene alguna pregunta sobre nuestras prácticas de privacidad por favor póngase en contacto con cualquier miembro del personal en esta oficina

Patients name (nombre de paciente): _____
Patients signature (firma de pciente): _____
Date (fetcha):_____

If signed by someone other than the patient, please indicate(Si es firmado por alguien que no sea el paciente, indique:_____
Relationship (relation) __Parent or gusrdian (Padre o guardián):
__Guardian or conservator of an incompetent patient(Tutor o curador de un paciente incompetent)
__Other (otro) Please specify(Por favor especifica)_____

Exceptions(Excepciones)

Medical Rehab Accident Injury may share my health informatiom with the following individuals:
(puede compartir mi información de salud con las siguientes personas)

Name (nombre):_____ Initials(iniciales)

Medical Rehab Accident Injury Center may send a report to my attorney:
(puede enviar un informe a mi abogo(a):
Name (nombre):_____ Initials (iniciales)

Medical Rehab Accident Injury Center 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 (Fetcha):_____ Witness name Print(Testigo nombre)_____

DATE _____

ACCIDENT QUESTIONNAIRE
Cuestionario de Accidentes

NAME _____ **Date of Accident** _____
NOMBRE **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

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

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

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

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

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 ?_____

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

_____

_____

_____

_____

_____

DATE _____

SYMPTOMS
SINTOMAS

NAME _____ **Date of accident** _____
NOMBRE **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 ?
___Headaches
Dolor de cabeza
___Dizziness
Mareo
___Difficulty walking
Dificultad para caminar
___Balance problems
Problemas de equilibrio
___Confused
Confusion
___Sensitive to noise
Sensible al ruido
___Sensitive to light
Sensible a la luz
___Trouble concentrating
Dificultad para concentrarse
___Trouble remembering
Problemas para recordar
___Trouble speaking
Dificultad para hablar
___Tired or fatigued
Cansancio o fatigado
___Appetite changed
Cambio en apetito
___Sleeping more or less than usual
Duerme más o menos de lo usual
___Vision problems; blurry, double vision
Problemas de la vista; borrosa , visión doble
___Trouble reading or writing
Dificultad para leer o escribir
___Nausea/Vomiting
Náuseas / vómitos
___Depressed or sad
Deprimido o triste
___Mood swings
Cambios de humor
___Angry or agitated
Enojado o agitado

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**
5. ___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

6. **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

7. **OTHER AREAS OF PAIN - Otros áreas de dolor**

___Right shoulder Hombro derecho	___Right wrist Muñeca derecha	___Right hip Cadera derecha	___Right leg/ankle Pierna derecha / tobillo
___Left shoulder Hombro izquierdo	___Left wrist Muñeca izquierda	___Left hip Cadera izquierda	___Left leg/ankle Pierna izquierda / tobillo
___Right elbow Codo derecho	___Right hand Mano derecha	___Right knee Rodilla derecha	___Right foot Pie derecho
___Left elbow Codo izquierdo	___Left hand Mano izquierda	___Left knee Rodilla izquierda	___Left foot Pie izquierdo