

SWANK CHIROPRACTIC SPORTS MEDICINE & WELLNESS CENTER, P.A.

Dr. Timothy A. Swank, D.C., C.C.S.P.

AUTOMOBILE ACCIDENT INFORMATION

Patient # _____

Date: _____ Name: _____

Permanent Address: _____

City: _____ State: _____ Zip: _____

Phones: Home: _____ Cell: _____ Work: _____

Birth Date: _____ Sex: M F SS# _____ E-mail: _____

Marital Status: S M W D # of Children: _____ Spouse Name: _____

Emergency Contact: _____ Phone _____

Business/ Employer: _____ Occupation: _____

How did you find out about our office? _____

(If referred by someone, please give us their name so we can thank them!)

Who is your Primary M.D.? _____ Phone _____

YOUR AUTO INS. INFO.

PERSON AT FAULT AUTO INS. INFO.

Name of Ins: _____

Policy #: _____

Adjustors Name: _____

Medpay: Y N Amount: _____

Name of Ins: _____

Policy #: _____

Adjustors Name: _____

Claim #: _____

MEDICAL COVERAGE

ATTORNEY INFO

Name of Ins: _____

Subscribers Name: _____

Subscribers DOB: _____

Subscribers Employer: _____

Policy #: _____

Group #: _____

Have you retained an Attorney Y N

Attorneys Name: _____

Phone: _____

Case #: _____

Fax #: _____

PLEASE READ CAREFULLY AND SIGN BELOW

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. If applicable, I understand that Swank Chiropractic Center, PA will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid to this Chiropractic Office will be credited to my account upon receipt. I also give this office power of attorney to endorse checks made out to me, to be credited to my account. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment.

I hereby authorize and release the doctor and his/her assistants to administer treatment, physical examinations, X-ray studies, laboratory procedures, chiropractic care or any other services that he deems necessary in my case: and I further authorize him /her to disclose all or part of my patient record to any person or corporation which is or may be liable under a contract to the clinic ,or to the patient or to a family member or employer of the patient for all or part of the services rendered to me including and not limited to hospital or medical service companies, insurance co., worker's compensation carriers, welfare funds or employers.

Acknowledgement of Receipt: I acknowledge that I have received a copy of Swank Chiropractic Center, P.A. Financial and Consent Policies and I fully understand and agree to each item listed.

Patients Signature: _____ Date: _____

Authorization to Treat Minor

I hereby represent the above named patient as a MINOR and give authorization for full chiropractic care and treatments. I agree to be financially responsible for services rendered to minor listed above.

Parent/ Guardian Signature: _____ Relationship: _____

Date: _____ Witnessed by: _____

SWANK CHIROPRACTIC SPORTS MEDICINE & WELLNESS CENTER, P.A.

Timothy A. Swank, D.C., C.C.S.P.

Name: _____

Date: _____

Patient # _____

Accident Information

Date and time of accident _____ am / pm

Were you the (circle one): **Driver** **Front Passenger** **Rear Passenger**

Were there others in the car with you? **YES NO** # of people _____

Was a traffic violation issued? **YES NO** To whom? _____

Were police notified? **YES NO** **Please provide copy of the police report for our records.**

Were there any witnesses? **YES NO** Were you wearing seat belt? **YES NO**

Was this vehicle equipped with airbags? **YES NO** Did they inflate? **YES NO**

In relation to the base of your skull, where was the headrest (circle one)? **ABOVE BELOW BASE**

What did your vehicle impact (circle one)? **ANOTHER VEHICLE OTHER**

If other, please explain: _____

Did any part of your body strike anything in the vehicle? **YES NO**

If yes, please explain: _____

Make / model of the vehicle you were in: _____

Name of location/street on which you were traveling: _____

What direction were you headed (circle one)? **N S E W** Approx. speed of your car? _____

Did the impact to your vehicle come from the (circle one): **FRONT REAR RT SIDE LT SIDE**

During the impact, were you facing: **RIGHT LEFT FORWARD**

Were you (circle one) **AWARE** or **SURPRISED** by the impact?

If accident vehicle made impact with another vehicle: MAKE: _____ MODEL: _____

Direction other vehicle was headed (circle one): **N S E W** Approx. speed of the other car? _____

In your words, please describe the accident: _____

Did the accident render you unconscious? **YES NO** If yes, for how long? _____

Please describe how you felt immediately after the accident: _____

Have you gone to a hospital or seen any other Doctor? **YES NO**

When did you go (circle one)? **JUST AFTER ACCIDENT NEXT DAY 2+DAYS LATER**

How did you get there (circle one)? **AMBULANCE PRIVATE TRANSPORTATION**

Name of Hospital and/or attending Doctor _____

Was he/she a (circle one): **D.C. M.D. D.O. P.A.**

Describe any treatment you received _____

Were x-rays taken? **YES NO**

Was medication prescribed? **YES NO**

Have you been able to work since this injury? **YES NO**

How much time have you missed from work due to the accident? _____

Explain: _____

SWANK CHIROPRACTIC SPORTS MEDICINE & WELLNESS CENTER, P.A.
Timothy A. Swank, DC, CCSP

Name: _____

Date: _____

Patient # _____

Please check the symptoms that are a result of this accident:

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Difficulty Sleeping | <input type="checkbox"/> Jaw Problems | <input type="checkbox"/> Nausea |
| <input type="checkbox"/> Memory Loss | <input type="checkbox"/> Irritability | <input type="checkbox"/> Arm/ shoulder pain | <input type="checkbox"/> Back Pain |
| <input type="checkbox"/> Headache(s) | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Numb hands/ fingers | <input type="checkbox"/> Lower Back Pain |
| <input type="checkbox"/> Blurred Vision | <input type="checkbox"/> Tension | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Back Stiffness |
| <input type="checkbox"/> Buzzing in ear | <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Leg Pain |
| <input type="checkbox"/> Ears Ringing | <input type="checkbox"/> Neck Stiffness | <input type="checkbox"/> Upset Stomach | <input type="checkbox"/> Numb Feet/ Toes |
| <input type="checkbox"/> Other: _____ | | | |

Is your condition getting worse? (circle one) **YES** **NO** **CONSTANT** **COMES AND GOES**

Indicate your degree of comfort while performing the following activities:

	COMFORTABLE	UNCOMFORTABLE	PAINFUL
Lying on back	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lying on side	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lying on stomach	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Running	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sports	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Working	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lifting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bending	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kneeling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pulling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reaching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If you have any other conditions that affect your work performance, please explain them: _____

If you favor any body part while working, explain what is involved: _____

Since this injury are your symptoms (circle one) **SAME** **BETTER** **WORSE**

To evaluate the effect that continuing work will have on your recovery please complete the following:

How many hours are in your normal work day? : _____

Please indicate your daily job duties and any activities which you are occasionally asked to perform:

- | | | |
|-----------------------------------|-----------------------------------|---|
| <input type="checkbox"/> Standing | <input type="checkbox"/> Driving | <input type="checkbox"/> Operating equipment |
| <input type="checkbox"/> Sitting | <input type="checkbox"/> Twisting | <input type="checkbox"/> Working with arms above head |
| <input type="checkbox"/> Walking | <input type="checkbox"/> Crawling | <input type="checkbox"/> Typing |
| <input type="checkbox"/> Lifting | <input type="checkbox"/> Bending | <input type="checkbox"/> Stooping |

Other: _____

What positions can you work in with minimum physical effort and for how long?

Do you work with others who can help you with any heavy lifting? **YES** **NO**

While in recovery is there any light duty work you could request? **YES** **NO**

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Name: _____

Date: _____

Patient # _____

Pre-consultation

Doctor's Notes

Have you ever been under chiropractic care before? Yes No

Previous Chiropractic Care: _____

When? : _____ Where? : _____

MAJOR COMPLAINT: _____

Describe your pain and its location: _____

When did the symptoms begin (date)? _____

Other doctors seen for this condition: _____

Does the pain radiate into other areas? Yes No

If yes, please list other areas: _____

What makes your condition better? _____

What makes your condition worse? _____

Have you had similar conditions in the past? _____

Activities or movements that you find difficult/painful to perform (circle)

Sitting Walking Bending Lying Lifting

Type of pain (circle all that apply): **Sharp Dull Throbbing Aching Burning**

Tingling Numbness Cramping Stiffness Swelling Other _____

Is pain interfering with: **Work Sleep Daily Routine Recreation**

Health History

Medications currently taking: *Prescribed* _____

Over the counter _____

Vitamins currently taking: *Regularly* _____

Occasionally: _____

Intake How much, How often

Cigarettes _____

Alcohol _____

Sugar _____

Water _____

Sleep _____

Intake How much, How often

Coffee _____

Tea _____

Drugs _____

Exercise _____

Appetite _____

FEMALES ONLY: Are you pregnant? Yes ___ No ___ Unsure ___ Date of last period _____

Are you Nursing? Yes ___ No ___

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Dr. Timothy A. Swank, D.C., C.C.S.P.

Name: _____

Date: _____

Patient # _____

ASSIGNMENT

I hereby instruct and direct my insurance company to pay by check made out and mailed directly to this clinic the professional or medical expense benefit allowable and payable under my current insurance policy as payment toward the total charges fro professional services rendered by this clinic.

*A photocopy of this assignment shall be considered as effective and valid as the original.

RELEASE OF INFORMATION

I authorize this office, known as Swank Chiropractic Center, P.A. to release any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case and herby forever release Swank Chiropractic Center, P.A., its agents and employees of any consequence thereof.

RELEASE OF MEDICAL RECORDS

You are herby authorized and instructed to release to Timothy Swank, D.C., Swank Chiropractic Center, P.A., 3731 NW Cary Parkway, Suite 101, Cary, NC 27513 all information/records concerning treatment and/or involvement in the care of my health.

FINANCIAL RESPONSIBILITY

I agree to be financially responsible for all charges incurred at Swank Chiropractic Center, P.A. including my insurance deductible, co-payment and any services rejected by insurance company or and other entity responsible for payment.

REFERRALS/AUTHORIZATIONS

I agree to pay for all services when a referral from my primary care physician was not received prior to being seen or authorization from my insurance company was not obtained at the time of my visit.

ACKNOWLEDGMENT OF RECEIPT

I acknowledge that I have received a copy of Swank Chiropractic Center, P.A. Financial & Consent Policies and I fully understand and agree with each item listed.

I have read, understand, and accept the items listed above.

(patient/guardian signature)

(date)