Family Chiropractors of Montclair
39 Watchung Plaza – Montclair, NJ 07042
(973)783-5666

AUTO ACCIDENT FORM

Name: _____ **Date of Birth:** _____ **Date**: _____

Marital Status: □ Single □ Married □ Widowed □ Divorced □ Child

Height: _____ **Weight:** _____ **Blood Pressure:**_____/_____

Address: _____

City: _____ State: _____ Zip: _____

SS#: _____ Email:_____

Primary Phone: _____ Secondary Phone:_____

Occupation: _____ Employer: _____

Work Phone: _____ Ext._____

Have you been diagnosed with:

Asthma? ☐ Yes ☐ No

High Blood Pressure? ☐ Yes ☐ No If yes, what was it at high point? _____/_____

Diabetes? ☐ Yes ☐ No If yes, please specify: ☐ Type I ☐ Type II

Insurance Information:

Insured Name: _____ Insurance Company: _____

Insurance Company Address: _____

_____

Claim Adjuster: _____ Phone #: _____ Ext:_____

POLICY #: _____CLAIM #:_____

1. What was the date of the accident? _____
2. Was a police report written up for this accident? □ Yes □ No
3. In what city and State did the accident occur? _____
4. Describe the accident in your own words: What Happened? (Continue on back if necessary)

_____

_____

5. What was your position in the car? □ Driver □ Passenger
   If Passenger, where were you sitting? □ Front □ Right Rear □ Left Rear

6. Was your vehicle struck by another vehicle? □ Yes □ No
   Angles of impact… First Collision: □ Front □ Back □ Left □ Right
   If Second Collision: □ Front □ Back □ Left □ Right

7. What type of vehicle were you in? _____

8. What type of vehicle impacted yours? _____

9. Were you wearing a seat belt? □ Yes □ No

10. Did you brace for impact? □ Yes □ No … □ I braced with my hands □ I braced with my feet

11. Which way were you facing at the time of the impact? □ Straight ahead □ Left □ Right

12. Did you strike another vehicle at time of impact? □ Yes □ No
If yes, please specify what part of your body struck what
□ Steering Wheel _____ □ Dashboard _____
□ Windshield _____ □ Roof _____
□ Left Side Door _____ □ Right Side Door _____
□ Other _____

13. Immediately after the accident, how did you feel? □ Dizzy/Dazed □ Disoriented □ Unconscious
□ Nervous □ Nauseous □ Upset □ Weak
□ Other: _____

14. Did your vehicle hit anything after the accident?
If yes, please describe: _____

15. During and after the crash, what happened to your vehicle? (Select all that apply)
□ Kept Going Straight □ Spun Around
□ Kept going but was hit by car in front □ Spun around and hit stationary object
□ Was hit by another vehicle □ Hit a stationary object

16. Did you lose consciousness during the accident? □ Yes □ No

17. Did your head hit anything during the accident? □ No □ Yes, describe: _____

18. Did your face hit anything during the accident? □ No □ Yes, describe: _____

19. Did your shoulders hit anything during the accident? □ No □ Yes, describe: _____

20. Did your neck hit anything during the accident? □ No □ Yes, describe: _____

21. Did your chest hit anything during the accident? □ No □ Yes, describe: _____

22. Did your hips hit anything during the accident? □ No □ Yes, describe: _____

23. Did your knees hit anything during the accident? □ No □ Yes, describe: _____

24. Did your feet hit anything during the accident? □ No □ Yes, describe: _____

25. What was damaged in your vehicle? (Select all that apply)

□ Windshield	□ Rear bumper	□ Mirror
□ Steering Wheel	□ Front Bumper	□ Knee bolster
□ Dashboard	□ Trunk	□ Back Right door
□ Seat frame	□ Front Left door	□ Completely Totaled
□ Side Window	□ Front Right door	
□ Back Window	□ Back Left door	

26. **Did you go to the hospital?** □ Yes □ No If yes, for how long? _____

When? □ At time of accident □ Next day
How did you get there? □ Ambulance □ Police Car □ Private Transportation

Name of Hospital: _____

Attended by Dr. _____

27. What treatment was given? **(Check all that apply)**

□ None □ placed in a cervical collar □ x-rayed □ given stitches □ Bandaged □ Medication

List the Medications Given: _____

□ Given instructions regarding concussions □ given instructions regarding sprains/strains

□ Physical Therapy □ instructed to call an Orthopedic surgeon □ instructed to call a private physician

□ Referred to this office for treatment: □ Other _____

28. If you were x-rayed at the hospital, check where on your body:

□ Neck □ Mid-Back □ Lower Back □ Other: _____

29. Have you seen any other doctors as a result of this accident? □ Yes □ No

If yes, whom? _____

30. Additional Comments: _____

_____

31. List all surgical procedure you have had: _____

_____

32. Have you ever been hospitalized (other than above surgeries & accident)? □ Yes □ No

If yes, why? _____

33. **INDICATE IF ANY FAMILY MEMBERS HAVE THE FOLLOWING (and what type, if applicable):**

□ Rheumatoid Arthritis □ Diabetes:_____ □ Lupus □ Other: _____
□ Heart Problems □ Cancer: _____ □ ALS

34. For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" column.

past present	past present	past present
☐ ☐ Headaches	☐ ☐ Asthma	☐ ☐ Muscular Incoordination
☐ ☐ Neck Pain	☐ ☐ Chronic Sinusitis	☐ ☐ Visual Disturbances
☐ ☐ Upper Back Pain	☐ ☐ High Blood Pressure	☐ ☐ Dizziness
☐ ☐ Mid Back Pain	☐ ☐ Heart Attack	☐ ☐ Diabetes
☐ ☐ Low Back Pain	☐ ☐ Chest Pains	☐ ☐ Excessive Thirst
☐ ☐ Shoulder Pain	☐ ☐ Stroke	☐ ☐ Frequent Urination
☐ ☐ Elbow/ Upper Arm Pain	☐ ☐ Angina	☐ ☐ Smoking/ Tobacco Use
☐ ☐ Wrist Pain	☐ ☐ Kidney Stones	☐ ☐ Drug/ Alcohol Dependence
☐ ☐ Hand Pain	☐ ☐ Kidney Disorders	☐ ☐ Allergies
☐ ☐ Hip Pain	☐ ☐ Bladder Infection	☐ ☐ Depression
☐ ☐ Upper Leg Pain	☐ ☐ Painful Urination	☐ ☐ Systemic Lupus
☐ ☐ Knee Pain	☐ ☐ Loss of Bladder Control	☐ ☐ Epilepsy
☐ ☐ Lower Leg Pain	☐ ☐ Prostate Problems	☐ ☐ Dermatitis/ Eczema/ Rash
☐ ☐ Ankle/ Foot Pain	☐ ☐ Abnormal Weight Gain/ Loss	☐ ☐ Other:_____
☐ ☐ Jaw Pain	☐ ☐ Loss of Appetite	
☐ ☐ Joint Pain/ Stiffness	☐ ☐ Abdominal Pain	**For Females Only:**
☐ ☐ Arthritis	☐ ☐ Ulcer	☐ ☐ Birth Control Pills
☐ ☐ Rheumatoid Arthritis	☐ ☐ Hepatitis	☐ ☐ Hormonal Replacement
☐ ☐ Cancer	☐ ☐ Liver/ Gall Bladder Disorder	☐ ☐ Pregnancy
☐ ☐ Tumor	☐ ☐ General Fatigue	

36. Please list all Prescription Medications you are currently taking: Check here if not taking any medications: ☐

Name of Drug: i.e. Lipitor	**Strength and Directions:** i.e. 10mg, twice daily	**Prescribing physician**

37**. Are you allergic to any medicines?** Check here if you do not have any medicinal allergies: ☐

Name of Medication: i.e: penicillin	**Reaction:** i.e: Rash and headache

CHIEF Complaints or Symptoms:

Neck Pain (Check off areas where the pain runs into from the neck) ☐ Check here if none

☐ Right Shoulder ☐ Right Arm ☐ Right Forearm ☐ Right Hand
☐ Left Shoulder ☐ Left Arm ☐ Left Forearm ☐ Left Hand

Headache Migraine Headaches Upper Back Pain Ringing in Ears
Blurry Vision Wrist Pain Jaw Pain Dizziness Nervousness
Fatigue Anxiety Depression Excessive Irritability
Fear of driving in car Loss of concentration Jaw clenching Grinding teeth at night
Nightmares Difficulty sleeping at night

Low Back Pain (Select the areas of radiation, if any) ☐ Check here if none

buttocks left buttock left thigh left knee left foot
right buttock right thigh right knee right foot

Hip Pain Left Right Bilateral
Knee Pain Left Right Bilateral
Foot Pain Left Right Bilateral

Numbness:

☐ Left Hand ☐ Left Foot ☐ Left Leg ☐ Left Upper Arm
☐ Right Hand ☐ Right Foot ☐ Right Leg ☐ Right Upper Arm

Additional Symptoms and Complaints: _____
_____
_____

Have you lost any time from work due to injuries? ☐ Yes ☐ No If yes, what dates? ____/____/_____ to ____/____/_____ Type of employment:

_____

Have you had previous injuries or accidents? Yes No

Description of previous Accident: _____

Description of previous injuries: _____

Is there any residual pain from the previous injury? Yes No

How much better did you feel prior to your current condition? (1-100%) _____

PLEASE READ BEFORE SIGNING

I understand that Family Chiropractors of Montclair is permitted by law to use my personal health information to facilitate payment of any fees and expenses. Family Chiropractors of Montclair has agreed to assist me in billing my auto insurance and any and all other applicable collateral sources. Although the practice will await their payment, I agree I am fully and personally responsible for all fees I incur in connection with service rendered for the purpose of today's encounter as well as any future services.

I HAVE READ THE ABOVE INFORMATION AND CERTIFY IT TO BE TRUE AND CORRECT. I HEREBY AUTHORIZE FAMILY CHIROPRACTORS OF MONTCLAIR TO PROVIDE ME WITH CHIROPRACTIC CARE IN ACCORDANCE WITH THE STATE'S STATUES.

_____ _____

PATIENT'S SIGNATURE DATE

HIPPA FORM

We are required by State and Federal Law to maintain the privacy of your patient file and the protected health information therein. We are also required to provide you with this notice of our privacy practices with respect to your health information. We are further required by law to abide by the terms of this notice while it is in effect.

We reserve the rights to alter or amend the terms of this privacy notice. IF changes are made to our privacy notice we will notify you, in writing, as soon as possible following the changes. Any change in our privacy notice will apply for all of your health information in our files.

f you have a complaint regarding our privacy notice, our privacy practices, or any aspect of our privacy activities, you should direct your complaint to:

Dr. Luis Mizraji. Privacy Officer
If you would like further information about our privacy policies and practices, please contact:

Dr. Luis Mizraji. Privacy Officer
You also have the right to lodge a complaint with the Secretary of the Department of Health and Human Services. If you lodge a complaint with this office or with the Secretary, your care will continue and you will not be disadvantaged by this office or our staff in any manner whatsoever.
This notice is effective as of the date of execution listed below. This notice, and any alterations or amendments made here to will expire seven years after the date upon which the record was created. My signature acknowledges that I have read through this document and that upon my request I have received a copy of this notice for my personal records.

_____ _____ _____

Name (please print) Signature Date

If you are a minor, your parent or guardian must sign or in the event of other representation issues, please have the following executed by the appropriate representing party.

_____ _____ _____

Personal Representative (please print) Personal Representative Signature Date

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Health Insurance Financial Policy

Since most health insurance plans have a deductible, you must pay 100% of your charges until your deductible is satisfied. Once you have met your deductible, we will accept authorization for direct payment of benefits to this office. You must provide us a copy of your health insurance card.

Upon receipt of this information, we will contact your company to verify the eligibility of chiropractic benefits. All information provided to us by your insurance company included any policy limitations or exclusions will be discussed with you. Since most health insurance plans do not reimburse health care expenses 100%, you may be responsible for your co-payment/co-insurance. CO-PAYMENTS ARE DUE AT THE TIME SERVICES ARE RENDERED.

Patients selecting this option understand this office submits bills and awaits direct payment from insurance companies as a courtesy, and that in no way relieves patients of their financial responsibility to this office. If your insurance company denies or delays reimbursement to this office for any reason, the allowable expenses are your responsibility. MONITORING ANY POLICY LIMITATIONS IS CONSIDERED THE RESPONSIBILITY OF THE PATIENT.

I authorize all insurance companies, third party payers and attorney's to make direct payment of my benefits to Family Chiropractors of Montclair for all monies due to my account for the services I have received. If my policy prohibits assignment, I direct my insurance company to mail all checks made payable to me, directly to Family Chiropractors of Montclair at 39 Watchung Plaza, Montclair, NJ 07042.

_____ _____

Patient Signature Date

_____ _____

Witness Signature Date