

Health 1st Chiropractic
1660 E Main Str. Ste 103
Plainfield, In 46168
P317-839-6686 F 317-839-7247

Dear Patient: This information is considered confidential. We need this information to help determine how chiropractic may help you, as well as filling out the necessary insurance forms. Please take the time to complete this form as accurately as possible. Thank you.

Name _____ Sex _____ Today's Date ____/____/____

Address _____ Home Tel (____) _____ Work Tel (____) _____

City, Zip _____ Soc. Sec _____ - ____ - ____ Birth date ____/____/____

Employer _____ Occupation _____

Marital Status _____ Email Address _____

=====

1) Date and time of accident ____/____/____ ____ am / pm

2) Location where accident occurred: Street _____ City _____
State _____

3) Type of accident: a. Auto Collision _____ b. Pedestrian hit by car _____ c. Bicycle accident _____, d.
Slip and Fall _____ e. Work Accident _____.

4) Please explain how the accident happened:

5) How many vehicles were involved in the accident? _____

6) Auto Collision: What part of your car was hit? Back end _____, Back end passenger side _____,
Back end driver side _____,
Front end _____, Front end passenger side _____, Front end driver side _____, Side impact:
Side front _____, Side middle _____, Side rear _____

Where were you in the car? The driver of the car _____, Passenger in a car _____, If Passenger were you in: front seat _____,

Back Seat Drivers side _____, Back Seat Middle _____, Back Seat Passenger side _____.

a. Was your head turned upon impact? _____ b. Were you leaning forward at the time of impact? _____ c. Was your body turned at the time of impact? _____ d. Did you brace for the accident? _____ e. Were you wearing your seat belt? _____ f. Did the airbag deploy? _____ g) Did you bump your head during the accident? _____ If yes, what part of your head was struck? _____

Where on the car did you hit your head? _____

h) Was anything other than another car struck? (ie: building, pole, etc) _____

i) Were you ejected from the vehicle? _____ j) Were any other body parts injured? _____

7) List the extent of injuries/symptoms as you know them:

8) When did the symptoms first appear? _____

9) Where did you go immediately after the accident? Home _____ Emergency room _____ other _____

a) If you went to an emergency room, please list name and address of hospital

b) Were x-rays taken? Yes ___ No ___ What area of body? _____

c) Was medication prescribed? Yes ___ No ___ Name: _____

d) What was the Doctor's diagnosis and recommendation? _____

10) Have you been seen by any other doctors or chiropractors for this condition? Yes ___ No ___

If so, please fill out below

a) Name and address of doctor(s): _____

b) Dates seen: _____

c) Were x-rays taken? _____ What treatment was provided? _____

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b) Dates seen: _____

c) Were x-rays taken? _____ What treatment was provided? _____

11) Have you ever had any injuries or complaints similar to those you are now experiencing? Y ___ N ___

Describe: _____

12) Have you previously seen a chiropractor for unrelated injuries? _____

a) Please explain _____

13) Did you miss any time at work because of this injury? Yes ___ No ___

If yes, please list specifically when: From _____ to _____

14) Please describe in detail your physical work activities: (i.e. sitting for 2-3 hours in front of a computer screen, lifting heavy objects....

Insurance Information:

1) Are you the owner of the vehicle you were traveling in? Yes ___ No ___

If not, please list name and address of owner:

Your relationship to owner _____

2) Insurance company of vehicle you were traveling in:

Policy # _____ Claim # _____

Adjuster _____ phone# _____

3) Insurance company of other vehicle in accident:

claim# _____

Adjuster _____ phone# _____

Owner's name and address _____

4) Are you covered by any type of health insurance? Yes ___ No ___

If so, please list insurance company name and policy #: (please provide front desk with card)

5) Are you the policy holder? _____ If not, policy holders name and dob _____

6) Have you obtained an attorney? Yes ___ No ___

If so, please list name and phone number:

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this Chiropractic office will prepare any necessary reports and form to assist me in making collection from the insurance companies. However, I clearly understand and agree that all services rendered to me are charged to me, and that ultimately I am personally responsible for payment.

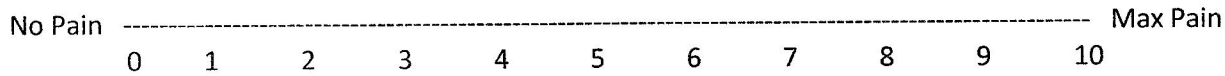
Patient name _____ Date _____

Patient signature: _____ Date _____

Guardian name _____ Relationship to patient _____

Guardian signature _____ Date _____

1) Indicate with a **mark** on this line, the level of pain you are now experiencing:



2) Listed below are 5 types of pain. Select the type (or types) of pain you are experiencing.

3) Mark the body figures below to indicate where on the body the pain is being felt.

XXXXXXXX
Numbness XXXXXXXX

SSSSSSSS
stabbing SSSSSSSSS

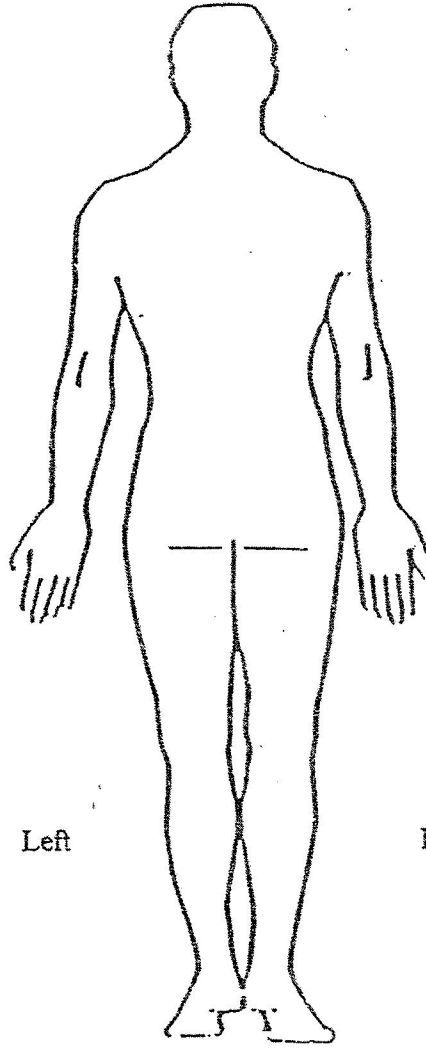
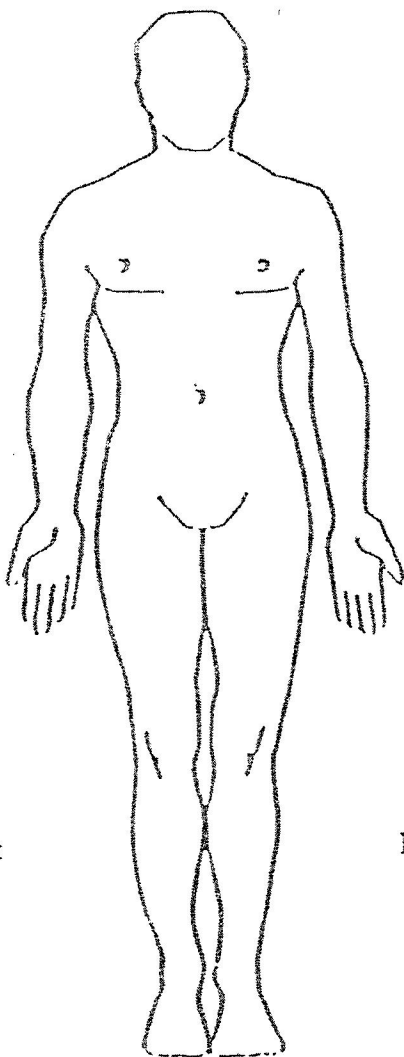
/////////
Aching ////////////

OOOOOOO
Pins and needles OOOOOOO

+++++++
Burning ++++++++

FRONT

BACK



Right

Left

Left

Right

PATIENT-ATTORNEY
Medical Lien Agreement

I, _____ do hereby authorize **Health 1st Chiropractic of Plainfield Inc.** to furnish you, _____ my attorney, with prepaid copies of medical records relevant to my injury or accident for which he/she is representing me.

I further authorize and direct my attorney to pay directly to **Health 1st Chiropractic of Plainfield Inc.** such sums of monies as may be due and owing to them, (a) for medical services rendered to me for the injury and/or, (b) for any other services, supplies, or reports, and/or (c) legal medical (i.e. impairment rating reports, attorney-physician conferences, and depositions) and to withhold such sums from any settlement or judgment as may be necessary to adequately protect and pay for my treatment. I hereby grant **Health 1st Chiropractic of Plainfield Inc.** a lien on my claim against and all proceeds of any settlement or judgment which may be paid to you, my attorney, or myself as the result of the injuries for which I have been treated for/or other related services.

I fully understand that I am directly and fully responsible to the above healthcare provider for all medical bills submitted by them for services rendered to me and that this agreement is made solely for their additional protection and in consideration of the services provided. I further understand that such payment is not contingent on any insurance company's determination, with the exception of a recognized worker's compensation case, as to the appropriateness of services rendered and/or fees charged. Alternate third party payment, if accepted, is done as a courtesy provided by (attorney) _____.

By my signature below, I hereby waive and/or relinquish my right to contest and/or otherwise make any legal objections as to the appropriateness of this agreement and that my attorney has advised me of the same. I understand that this agreement shall be governed by the laws of the State of **Indiana**.

Patient Signature _____

Print name _____

Home address _____

ATTORNEY AGREEMENT AND ACCEPTANCE

The undersigned being the attorney for the above client (patient), does hereby agree to observe all the terms of the above agreement to withhold such sums from any settlement or judgment as may be necessary to adequately protect the above listed health care providers and to promptly pay such sums to them upon receipt of payment of any settlement or judgment without demand.

Date _____

Attorney's signature _____

Print name _____

State Bar No. _____

Address _____
