

Personal Injury Questionnaire

PATIENT INFORMATION

Date _____
SS # _____
DOB _____
Patient Name _____
Address _____

City _____ State _____ Zip _____
Email _____
Home Phone _____
Cell Phone _____
Work Phone _____
Employer / School _____
Occupation _____
Sex M F
 Married Widowed Single
 Separated Divorced Partnered
Referred to our office by _____

INSURANCE INFORMATION

Patient Health Insurance

Insurance Co. _____
Plan / ID # _____
Group # _____
Relationship to Policyholder
 Self Spouse Child

Assignment & Release

I certify that I and/or my dependant(s) have insurance coverage with the above named company. I assign directly to Dr. Mistretta all insurance benefits, if any, otherwise payable to me for services rendered.

Dr. Mistretta may use my health care information and may disclose such information to the above named insurance company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when the current treatment plan is complete.

X

Signature of Patient or Parent/Guardian

Please Print name of Patient or Parent/Guardian

Date

Relationship to Patient

Patient Motor Vehicle Insurance

Insurance Co. _____
Policy # _____
Medpay Y N Amount \$ _____
Claim # _____
Claims Adjuster _____
Phone _____

Liabe Party Motor Vehicle Insurance

Insurance Co. _____
Policy # _____
Claim # _____
Claims Adjuster _____
Phone _____

ATTORNEY INFORMATION

Name _____
Firm _____
Phone _____
Email _____

ACCIDENT INFORMATION

Date of Incident _____
Time of Incident _____
Liable Party _____
 Police notified Police Report attached
Were you knocked unconscious? Y N
Struck from Behind Front Left Right
You were Driver Passenger Front Back
 Seat belts used Other protective device
 Taken to hospital Facility Name _____
Name of other doctor(s) seeing _____

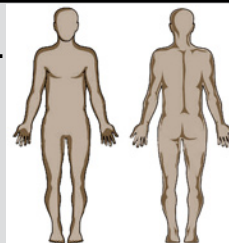
 X-Rays Prescription Medication Other
Prior injury to afflicted area(s)? Y N
Has your ability to work been affected? Y N
Are your symptoms Improving Same Worse

INJURY INFORMATION

Mark an X on the picture where you have pain, numbness or tingling.

Rate the severity from 1 to 10 _____

Sharp Burning Throbbing
 Dull Aching Shooting
 Swelling Tingling Numbness
Other _____





Frank J. Mistretta, D.C

AUTHORIZATION AND ASSIGNMENT

To: Frank J. Mistretta, D.C. Mistretta Chiropractic

Patient: _____

Date of Injury: _____

In consideration of you undertaking to treat me, I agree to the following:

- 1. You are authorized to release any information you deem appropriate concerning my physical condition to any insurance company, attorney, or adjuster in order to process any claim for reimbursement of charges incurred for services rendered me by you or any member of your staff acting on behalf.
2. I authorize the direct pay to you of any sum I now or hereafter owe you by my attorney out of the proceeds of any settlement of my case, and by any insurance company obligated to reimburse me for the charges for services or otherwise obligated to make payment to me or you based on in whole or in part upon the charges made for your service.
3. In the event any insurance company obligated by contractual agreement to make payment to me or to you for the charges made for services refused to make such payment upon demand by you, I hereby assign and transfer to you the cause of action that exists in my favor against any such company (the name(s) of which is believed to be correctly set forth under pertinent data below) and authorize you to prosecute said action either in my name or your name as you see fit and further authorize you to compromise, settle or otherwise resolve said claim as you see fir. However, it is understood that until all reasonable efforts have been made to collect sums due from the insurance company(s) contractually obligated, you will refrain for attempts to collect the amounts owed directly from me. I understand that what ever amounts you do not collect from insurance proceeds (whether it be all or part of what is due) I personally owe you.

Date: _____ (Patient/Guardian) Signature: _____

Insurance Company(s) Involved:

My Auto Insurance Carrier:

Liabile Party Insurance Carrier:

Claim #:

Claim #:



Frank J. Mistretta, D.C

DOCTOR'S LEIN

TO: Attorney or Insurance Company

RE: Reports and Doctor's Lien

Patient: _____
Address: _____

Date of Injury: _____

I do hereby authorize the above doctor to furnish you, my attorney or responsible insurance carrier, with full report of his examination, diagnosis, treatment, prognosis, etc., of myself in regard to the accident in which I was involved.

I hereby authorize and direct you, my attorney or responsible insurance carrier to pay directly to said doctor such sums as may be due and owing him for medical service rendered me both by reason of this accident and by reason of any other bills that are due his office and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect said doctor. And I hereby further give a lien on my case to said doctor against any and all proceeds of any settlement, judgment or verdict which may be paid to you, my attorney, or myself as the result of the injuries for which I have been treated or injuries in connection therewith.

I fully understand that I am directly and fully responsible to said doctor for all medical bills submitted by him for service rendered me and that this agreement is made solely for said doctor's additional protection and in consideration of his awaiting payment. And I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee.

Dated: _____

Patient's Signature: _____

The undersigned being attorney of record for the above patient does hereby agree to observe all of the terms above and agrees to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect said doctor above named.

Dated: _____

Attorney's Signature: _____

Insurance Representative: _____

Signature: _____