

Date _____

NAME: _____ ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____ HOME PHONE: _____

CELL PHONE: _____ SEX: _____ MARITAL STATUS: _____ D.O.B.: _____ AGE: _____

S.S. #: _____ # OF CHILDREN: _____ D.L. #: _____

EMPLOYER: _____ OCCUPATION: _____

NAME OF SPOUSE: _____ CELL PHONE: _____

NAME OF NEAREST RELATIVE: _____ HOME PHONE: _____
(NOT LIVING WITH YOU)

TYPE OF ACCIDENT: NONE WORK RELATED AUTO ACCIDENT SLIP AND FALL OTHER

DATE OF ACCIDENT: _____

BRIEFLY DESCRIBE SYMPTOMS: _____

LIST OTHER DOCTORS SEEN FOR THIS CONDITION: _____

MEDICAL HISTORY

- | | | |
|---|---|---|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> EPILEPSY | <input type="checkbox"/> HEPATITIS |
| <input type="checkbox"/> HIV | <input type="checkbox"/> HEART TROUBLE | <input type="checkbox"/> RHEUMATIC FEVER |
| <input type="checkbox"/> ANEMIA | <input type="checkbox"/> REPRODUCTIVE DISORDERS | <input type="checkbox"/> RHEUMATISM |
| <input type="checkbox"/> ASTHMA | <input type="checkbox"/> HIGH BLOOD PRESSURE | <input type="checkbox"/> SCARLET FEVER |
| <input type="checkbox"/> CANCER | <input type="checkbox"/> KIDNEY DISORDER | <input type="checkbox"/> TUBERCULOSIS |
| <input type="checkbox"/> CONVULSIONS | <input type="checkbox"/> MULTIPLE SCLEROSIS | <input type="checkbox"/> VENEREAL DISEASE |
| <input type="checkbox"/> DIABETES | <input type="checkbox"/> MUSCULAR DYSTROPHY | <input type="checkbox"/> GERMAN MEASELS |
| <input type="checkbox"/> DIGESTIVE DISORDER | <input type="checkbox"/> POLIO | |

ARE YOU PREGNANT? YES NO IF SO, WHAT IS YOUR DUE DATE? _____

ARE YOU ALLERGIC TO ANY MEDICATIONS? YES NO IF SO, WHAT KINDS? _____

ARE YOU CURRENTLY TAKING ANY MEDICATIONS? _____

HAVE YOU BEEN TREATED BY A PHYSICIAN FOR ANY HEALTH CONDITION IN THE PAST YEAR? YES NO

DESCRIBE CONDITION: _____

DO YOU HAVE HEALTH INSURANCE? YES NO

NAME OF INS CO: _____ PHONE: _____

NAME OF POLICY HOLDER: _____ POLICY HOLDER'S S.S. #: _____

MEMBER #: _____ GROUP #: _____

PATIENT SIGNATURE: _____ DATE: _____

DATE OF ACCIDENT: _____ TIME OF ACCIDENT: _____ AM PM

WORK RELATED ACCIDENT VICTIMS ONLY:

EMPLOYER: _____ TYPE OF BUSINESS: _____ PHONE: _____

HAS ACCIDENT BEEN REPORTED TO SUPERVISOR/EMPLOYER? YES NO

HAS A WORKER'S COMPENSATION CLAIM BEEN FILED? YES NO

TRAFFIC ACCIDENT VICTIMS ONLY:

WERE YOU THE: DRIVER PASSENGER PEDESTRIAN

IF PASSINGER, PLEASE INDICATE YOUR LOCATION IN THE VEHICLE: _____

YEAR/MAKE/MODEL OF VEHICLE YOU WERE IN: _____

YEAR/MAKE/MODEL OF OTHER VEHICLE INVOLVED IN THIS ACCIDENT: _____

WAS ACCIDENT REPORTED TO POLICE DEPARTMENT? YES NO

WERE ANY CITATIONS ISSUED? YES NO TO WHOM? _____

ACCIDENT DESCRIPTION:

EXPLAIN HOW THE ACCIDENT HAPPENED: _____

DID YOU GO TO THE HOSPITAL OR ANOTHER DOCTOR AFTER THE ACCIDENT? YES NO

WHERE DID YOU GO? _____

WHEN DID YOU GO? _____

HOW DID YOU GET THERE? PRIVATE TRANSPORTATION AMBULANCE

PLEASE CHECK THE FOLLOWING ACTIVITIES THAT AGGRAVATE YOUR CONDITION:

- | | | | |
|---|---------------------------------------|-----------------------------------|----------------------------------|
| <input type="checkbox"/> BENDING | <input type="checkbox"/> TURNING HEAD | <input type="checkbox"/> SNEEZING | <input type="checkbox"/> LIFTING |
| <input type="checkbox"/> STANDING | <input type="checkbox"/> REACHING | <input type="checkbox"/> SITTING | <input type="checkbox"/> WALKING |
| <input type="checkbox"/> STRAINING AT STOOL | <input type="checkbox"/> LYING DOWN | <input type="checkbox"/> COUGHING | |

PLEASE CHECK THE FOLLOWING SYMPTOMS YOU MAY BE EXPERIENCING:

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> BLURRED VISION | <input type="checkbox"/> FATIGUE | <input type="checkbox"/> SHORTNESS
IN BREATH | <input type="checkbox"/> HEAD SEEMS
TOO HEAVY |
| <input type="checkbox"/> BUZZING IN EARS | <input type="checkbox"/> DEPRESSION | <input type="checkbox"/> STIFF NECK | <input type="checkbox"/> CONSTIPATION |
| <input type="checkbox"/> MUSCLE JERKING | <input type="checkbox"/> INSOMNIA | <input type="checkbox"/> STOMACH UPSET | <input type="checkbox"/> LOSS OF BALANCE |
| <input type="checkbox"/> FAINTING | <input type="checkbox"/> NUMBNESS
IN FINGERS | <input type="checkbox"/> NUMBNESS IN TOES | |
| <input type="checkbox"/> DIARRHEA | <input type="checkbox"/> PINS AND NEEDLES
IN ARMS | <input type="checkbox"/> PINS AND NEEDLES
IN LEGS | |
| <input type="checkbox"/> DIZZINESS | | | |
| <input type="checkbox"/> HEADACHES | | | |

SYMPTOMS OTHER THAN ABOVE: _____

PATIENT SIGNATURE: _____ DATE: _____

AUTOMOBILE ACCIDENT QUESTIONNAIRE

DATE _____

PATIENT'S NAME _____

DATE OF ACCIDENT _____

THE FOLLOWING QUESTIONS PERTAIN TO YOU AND THE VEHICLE YOU WERE IN:

VEHICLE TYPE:

- CAR PICKUP
 VAN TRUCK
 STATION WAGON BUS
 OTHER _____

VEHICLE SIZE:

- SUBCOMPACT FULL-SIZE
 COMPACT MINI
 MID-SIZE LIGHT
 HEAVY OTHER _____

YOUR POSITION IN THE VEHICLE:

- DRIVER
 PASSENGER ----- LOCATION: LEFT MIDDLE RIGHT
 OTHER _____ FRONT PASSENGER REAR PASSENGER THIRD SEAT (REAR)

SPEED OF YOUR VEHICLE:

- STOPPED MOVING MODERATELY
 PARKED MOVING FAST
 SLOWING MOVING AT APPROX. _____ MPH
 MOVING SLOWLY

WHY VEHICLE WAS SLOWED OR STOPPED:

- TRAFFIC SIGNAL PARKING
 PEDESTRIAN TRAFFIC
 STOP SIGN BUSY INTERSECTION

COLLISION TYPE:

- DRIVER SIDE IMPACT HEAD ON COLLISION
 PASSENGER SIDE IMPACT REAR IMPACT
 FRONT IMPACT PEDESTRIAN INCIDENT

THE FOLLOWING QUESTIONS PERTAIN TO THE OTHER VEHICLE INVOLVED IN THE ACCIDENT:

VEHICLE TYPE:

- CAR PICKUP
 VAN TRUCK
 STATION WAGON BUS
 OTHER _____

VEHICLE SIZE:

- SUBCOMPACT FULL-SIZE
 COMPACT MINI
 MID-SIZE LIGHT
 HEAVY OTHER _____

CONDITIONS AT THE TIME OF ACCIDENT:

TIME OF DAY:

- FULL DAYLIGHT
 DAWN
 DUSK
 NIGHT

ROAD CONDITIONS:

- DRY
 DAMP
 WET
 SNOW COVERED
 ICE COVERED
 PATCHY ICE/SNOW

VISIBILITY:

- EXCELLENT
 GOOD
 FAIR
 POOR

VISIBILITY COMPROMISED BY:

- BRIGHTNESS
 DARKNESS
 RAIN
 SNOW
 FOG
 TRAFFIC

THE FOLLOWING QUESTIONS CONCERN THE MOMENT OF IMPACT OF THE ACCIDENT:

WHERE YOU...

- TOTALLY UNAWARE THAT THE ACCIDENT WAS IMPENDING
 AWARE THAT THE ACCIDENT WAS IMPENDING
 AWARE THAT THE ACCIDENT WAS IMPENDING AND BRACED FOR IT

RESTRAINTS: (CHECK ALL THAT APPLY)

- SEAT BELT
 SHOULDER HARNESS
 NO RESTRAINTS

IF YOU WERE THE DRIVER OF THE VEHICLE, WAS YOUR FOOT ON THE BRAKE PEDAL? YES NO KNOCKED OFF BY IMPACT

WAS THE AIR BAG DEPLOYED?

- CAR NOT EQUIPPED WITH AIR BAG
 AIR BAG DEPLOYED
 AIR BAG NOT DEPLOYED

WHAT POSITION WAS YOUR HEADREST IN?

- HIGH POSITION
 MIDDLE POSITION
 LOW POSITION

POSITION OF YOUR HEAD AT TIME OF IMPACT:

- FACING STRAIGHT AHEAD
- TILTED FORWARD
- ROTATED TO THE LEFT
- ROTATED TO THE RIGHT

POSITION OF YOUR BODY AT TIME OF IMPACT:

- STRAIGHT
- TILTED FORWARD
- ROTATED TO THE LEFT
- ROTATED TO THE RIGHT

DAMAGE TO THE VEHICLE YOU WERE IN:

- INCURRED MINIMAL DAMAGE
- INCURRED MODERATE DAMAGE
- INCURRED SEVERE DAMAGE
- WAS TOTALLED
- NOT KNOWN

WAS YOUR HEAD THROWN...?

- BACKWARD AND THEN FORWARD
- FORWARD AND THEN BACKWARD
- TO THE LEFT TO THE LEFT THEN THE RIGHT
- TO THE RIGHT TO THE RIGHT THEN THE LEFT

WAS YOUR BODY THROWN...?

- BACKWARD AND THEN FORWARD
- FORWARD AND THEN BACKWARD
- TO THE LEFT TO THE LEFT THEN THE RIGHT
- TO THE RIGHT TO THE RIGHT THEN THE LEFT
- ACROSS THE VEHICLE
- OUTSIDE THE VEHICLE UNDER THE VEHICLE

CITATIONS:

- NONE ISSUED
- YOURSELF
- DRIVER OF VEHICLE PATIENT WAS A PASSENGER OF
- DRIVER OF OTHER VEHICLE
- NOT SURE

AS A RESULT OF THE FORCE OF THE COLLISION, WHICH OBJECTS IN THE VEHICLE DID YOUR BODY STRIKE?

HEAD:

- | | |
|---|---------------------------------------|
| <input type="checkbox"/> STEERING WHEEL | <input type="checkbox"/> RIGHT DOOR |
| <input type="checkbox"/> DASHBOARD | <input type="checkbox"/> LEFT WINDOW |
| <input type="checkbox"/> WINDSHIELD | <input type="checkbox"/> RIGHT WINDOW |
| <input type="checkbox"/> ARMREST | <input type="checkbox"/> CONSOLE |
| <input type="checkbox"/> HEADREST | <input type="checkbox"/> GEAR SHIFT |
| <input type="checkbox"/> REAR VIEW MIRROR | <input type="checkbox"/> FRONT SEAT |
| <input type="checkbox"/> LEFT DOOR | <input type="checkbox"/> BACK SEAT |

TORSO:

- | | |
|---|---------------------------------------|
| <input type="checkbox"/> STEERING WHEEL | <input type="checkbox"/> RIGHT DOOR |
| <input type="checkbox"/> DASHBOARD | <input type="checkbox"/> LEFT WINDOW |
| <input type="checkbox"/> WINDSHIELD | <input type="checkbox"/> RIGHT WINDOW |
| <input type="checkbox"/> ARMREST | <input type="checkbox"/> CONSOLE |
| <input type="checkbox"/> HEADREST | <input type="checkbox"/> GEAR SHIFT |
| <input type="checkbox"/> REAR VIEW MIRROR | <input type="checkbox"/> FRONT SEAT |
| <input type="checkbox"/> LEFT DOOR | <input type="checkbox"/> BACK SEAT |

LEFT ARM:

- | | |
|---|---------------------------------------|
| <input type="checkbox"/> STEERING WHEEL | <input type="checkbox"/> RIGHT DOOR |
| <input type="checkbox"/> DASHBOARD | <input type="checkbox"/> LEFT WINDOW |
| <input type="checkbox"/> WINDSHIELD | <input type="checkbox"/> RIGHT WINDOW |
| <input type="checkbox"/> ARMREST | <input type="checkbox"/> CONSOLE |
| <input type="checkbox"/> HEADREST | <input type="checkbox"/> GEAR SHIFT |
| <input type="checkbox"/> REAR VIEW MIRROR | <input type="checkbox"/> FRONT SEAT |
| <input type="checkbox"/> LEFT DOOR | <input type="checkbox"/> BACK SEAT |

RIGHT ARM:

- | | |
|---|---------------------------------------|
| <input type="checkbox"/> STEERING WHEEL | <input type="checkbox"/> RIGHT DOOR |
| <input type="checkbox"/> DASHBOARD | <input type="checkbox"/> LEFT WINDOW |
| <input type="checkbox"/> WINDSHIELD | <input type="checkbox"/> RIGHT WINDOW |
| <input type="checkbox"/> ARMREST | <input type="checkbox"/> CONSOLE |
| <input type="checkbox"/> HEADREST | <input type="checkbox"/> GEAR SHIFT |
| <input type="checkbox"/> REAR VIEW MIRROR | <input type="checkbox"/> FRONT SEAT |
| <input type="checkbox"/> LEFT DOOR | <input type="checkbox"/> BACK SEAT |

LEFT LEG:

- | | |
|---|---------------------------------------|
| <input type="checkbox"/> STEERING WHEEL | <input type="checkbox"/> RIGHT DOOR |
| <input type="checkbox"/> DASHBOARD | <input type="checkbox"/> LEFT WINDOW |
| <input type="checkbox"/> WINDSHIELD | <input type="checkbox"/> RIGHT WINDOW |
| <input type="checkbox"/> ARMREST | <input type="checkbox"/> CONSOLE |
| <input type="checkbox"/> HEADREST | <input type="checkbox"/> GEAR SHIFT |
| <input type="checkbox"/> REAR VIEW MIRROR | <input type="checkbox"/> FRONT SEAT |
| <input type="checkbox"/> LEFT DOOR | <input type="checkbox"/> BACK SEAT |

RIGHT LEG:

- | | |
|---|---------------------------------------|
| <input type="checkbox"/> STEERING WHEEL | <input type="checkbox"/> RIGHT DOOR |
| <input type="checkbox"/> DASHBOARD | <input type="checkbox"/> LEFT WINDOW |
| <input type="checkbox"/> WINDSHIELD | <input type="checkbox"/> RIGHT WINDOW |
| <input type="checkbox"/> ARMREST | <input type="checkbox"/> CONSOLE |
| <input type="checkbox"/> HEADREST | <input type="checkbox"/> GEAR SHIFT |
| <input type="checkbox"/> REAR VIEW MIRROR | <input type="checkbox"/> FRONT SEAT |
| <input type="checkbox"/> LEFT DOOR | <input type="checkbox"/> BACK SEAT |



THE FOLLOWING QUESTIONS CONCERN THE TIME PERIOD IMMEDIATELY FOLLOWING THE ACCIDENT:

DID YOU LOSE CONSCIOUSNESS?

- YES
- NO

IMMEDIATELY FOLLOWING THE ACCIDENT, DID YOU FEEL...?

- DIZZY
- WEAK
- DAZED
- NERVOUS
- DISORIENTED
- NAUSEATED

WERE YOU ABLE TO WALK UNAIDED?

- YES
- NO

WHERE DID YOU GO?

- DROVE HOME
- DROVE TO WORK
- WAS DRIVEN HOME
- WAS DRIVEN TO WORK
- DROVE TO HOSPITAL
- DROVE TO SCHOOL
- WAS DRIVEN TO HOSPITAL
- WAS DRIVEN TO SCHOOL
- TAKEN TO HOSPITAL VIA AMBULANCE

NEXT DAY DISCOMFORT...?

- INCREASED
- DECREASED
- SAME

DID YOUR MAJOR COMPLAINTS EXIST BEFORE THE ACCIDENT?

- YES
- NO

IN WHAT AREAS DID YOU IMMEDIATELY FEEL PAIN?

- | | | | | | | |
|-------------------------------------|---------------------------------|-------------------------------|--------------------------------|---------|-------------------------------|--------------------------------|
| <input type="checkbox"/> HEAD | SHOULDER - | <input type="checkbox"/> LEFT | <input type="checkbox"/> RIGHT | HIP - | <input type="checkbox"/> LEFT | <input type="checkbox"/> RIGHT |
| <input type="checkbox"/> NECK | ARM - | <input type="checkbox"/> LEFT | <input type="checkbox"/> RIGHT | THIGH - | <input type="checkbox"/> LEFT | <input type="checkbox"/> RIGHT |
| <input type="checkbox"/> UPPER BACK | ELBOW - | <input type="checkbox"/> LEFT | <input type="checkbox"/> RIGHT | KNEE - | <input type="checkbox"/> LEFT | <input type="checkbox"/> RIGHT |
| <input type="checkbox"/> MID BACK | WRIST - | <input type="checkbox"/> LEFT | <input type="checkbox"/> RIGHT | CALF - | <input type="checkbox"/> LEFT | <input type="checkbox"/> RIGHT |
| <input type="checkbox"/> RIBS | HAND - | <input type="checkbox"/> LEFT | <input type="checkbox"/> RIGHT | ANKLE - | <input type="checkbox"/> LEFT | <input type="checkbox"/> RIGHT |
| <input type="checkbox"/> CHEST | FINGERS - | <input type="checkbox"/> LEFT | <input type="checkbox"/> RIGHT | FOOT - | <input type="checkbox"/> LEFT | <input type="checkbox"/> RIGHT |
| <input type="checkbox"/> ABDOMEN | BUTTOCK - | <input type="checkbox"/> LEFT | <input type="checkbox"/> RIGHT | TOES - | <input type="checkbox"/> LEFT | <input type="checkbox"/> RIGHT |
| <input type="checkbox"/> LOW BACK | <input type="checkbox"/> PELVIS | | | | | |

IN WHAT AREAS DID YOU EXPERIENCE LACERATIONS (CUTS)?

- | | | | | | | |
|-------------------------------------|---------------------------------|-------------------------------|--------------------------------|---------|-------------------------------|--------------------------------|
| <input type="checkbox"/> HEAD | SHOULDER - | <input type="checkbox"/> LEFT | <input type="checkbox"/> RIGHT | HIP - | <input type="checkbox"/> LEFT | <input type="checkbox"/> RIGHT |
| <input type="checkbox"/> NECK | ARM - | <input type="checkbox"/> LEFT | <input type="checkbox"/> RIGHT | THIGH - | <input type="checkbox"/> LEFT | <input type="checkbox"/> RIGHT |
| <input type="checkbox"/> UPPER BACK | ELBOW - | <input type="checkbox"/> LEFT | <input type="checkbox"/> RIGHT | KNEE - | <input type="checkbox"/> LEFT | <input type="checkbox"/> RIGHT |
| <input type="checkbox"/> MID BACK | WRIST - | <input type="checkbox"/> LEFT | <input type="checkbox"/> RIGHT | CALF - | <input type="checkbox"/> LEFT | <input type="checkbox"/> RIGHT |
| <input type="checkbox"/> RIBS | HAND - | <input type="checkbox"/> LEFT | <input type="checkbox"/> RIGHT | ANKLE - | <input type="checkbox"/> LEFT | <input type="checkbox"/> RIGHT |
| <input type="checkbox"/> CHEST | FINGERS - | <input type="checkbox"/> LEFT | <input type="checkbox"/> RIGHT | FOOT - | <input type="checkbox"/> LEFT | <input type="checkbox"/> RIGHT |
| <input type="checkbox"/> ABDOMEN | BUTTOCK - | <input type="checkbox"/> LEFT | <input type="checkbox"/> RIGHT | TOES - | <input type="checkbox"/> LEFT | <input type="checkbox"/> RIGHT |
| <input type="checkbox"/> LOW BACK | <input type="checkbox"/> PELVIS | | | | | |

AT THE HOSPITAL, WHAT AREAS WERE X-RAYED?

- | | | | | | | |
|-------------------------------------|---------------------------------|-------------------------------|--------------------------------|---------|-------------------------------|--------------------------------|
| <input type="checkbox"/> HEAD | SHOULDER - | <input type="checkbox"/> LEFT | <input type="checkbox"/> RIGHT | HIP - | <input type="checkbox"/> LEFT | <input type="checkbox"/> RIGHT |
| <input type="checkbox"/> NECK | ARM - | <input type="checkbox"/> LEFT | <input type="checkbox"/> RIGHT | THIGH - | <input type="checkbox"/> LEFT | <input type="checkbox"/> RIGHT |
| <input type="checkbox"/> UPPER BACK | ELBOW - | <input type="checkbox"/> LEFT | <input type="checkbox"/> RIGHT | KNEE - | <input type="checkbox"/> LEFT | <input type="checkbox"/> RIGHT |
| <input type="checkbox"/> MID BACK | WRIST - | <input type="checkbox"/> LEFT | <input type="checkbox"/> RIGHT | CALF - | <input type="checkbox"/> LEFT | <input type="checkbox"/> RIGHT |
| <input type="checkbox"/> RIBS | HAND - | <input type="checkbox"/> LEFT | <input type="checkbox"/> RIGHT | ANKLE - | <input type="checkbox"/> LEFT | <input type="checkbox"/> RIGHT |
| <input type="checkbox"/> CHEST | FINGERS - | <input type="checkbox"/> LEFT | <input type="checkbox"/> RIGHT | FOOT - | <input type="checkbox"/> LEFT | <input type="checkbox"/> RIGHT |
| <input type="checkbox"/> ABDOMEN | BUTTOCK - | <input type="checkbox"/> LEFT | <input type="checkbox"/> RIGHT | TOES - | <input type="checkbox"/> LEFT | <input type="checkbox"/> RIGHT |
| <input type="checkbox"/> LOW BACK | <input type="checkbox"/> PELVIS | | | | | |

WHERE DID YOU EXPERIENCE PAIN ON THE DAY FOLLOWING THE ACCIDENT?

- | | | | | | | |
|-------------------------------------|---------------------------------|-------------------------------|--------------------------------|---------|-------------------------------|--------------------------------|
| <input type="checkbox"/> HEAD | SHOULDER - | <input type="checkbox"/> LEFT | <input type="checkbox"/> RIGHT | HIP - | <input type="checkbox"/> LEFT | <input type="checkbox"/> RIGHT |
| <input type="checkbox"/> NECK | ARM - | <input type="checkbox"/> LEFT | <input type="checkbox"/> RIGHT | THIGH - | <input type="checkbox"/> LEFT | <input type="checkbox"/> RIGHT |
| <input type="checkbox"/> UPPER BACK | ELBOW - | <input type="checkbox"/> LEFT | <input type="checkbox"/> RIGHT | KNEE - | <input type="checkbox"/> LEFT | <input type="checkbox"/> RIGHT |
| <input type="checkbox"/> MID BACK | WRIST - | <input type="checkbox"/> LEFT | <input type="checkbox"/> RIGHT | CALF - | <input type="checkbox"/> LEFT | <input type="checkbox"/> RIGHT |
| <input type="checkbox"/> RIBS | HAND - | <input type="checkbox"/> LEFT | <input type="checkbox"/> RIGHT | ANKLE - | <input type="checkbox"/> LEFT | <input type="checkbox"/> RIGHT |
| <input type="checkbox"/> CHEST | FINGERS - | <input type="checkbox"/> LEFT | <input type="checkbox"/> RIGHT | FOOT - | <input type="checkbox"/> LEFT | <input type="checkbox"/> RIGHT |
| <input type="checkbox"/> ABDOMEN | BUTTOCK - | <input type="checkbox"/> LEFT | <input type="checkbox"/> RIGHT | TOES - | <input type="checkbox"/> LEFT | <input type="checkbox"/> RIGHT |
| <input type="checkbox"/> LOW BACK | <input type="checkbox"/> PELVIS | | | | | |

PATIENT'S SIGNATURE: _____

PATIENT: _____

ADDRESS: _____

ATTORNEY: _____

INSURANCE CARRIER: _____

ASSIGNMENT OF PAYMENT

My attorney and/or insurance carrier are hereby authorized and requested to pay directly to **LOUISIANA HEALTH & INJURY CENTERS** any monies due on my account, the same to be deducted from settlement made on my behalf.

Dated at _____ am/pm this _____ day of _____, 20____.
TIME DATE MONTH

Witness

Patient Signature

AUTHORIZATION OF RELEASE OF CASE RECORDS

I hereby authorize **LOUISIANA HEALTH & INJURY CENTERS** to disclose my medical records or any information, which he may have acquired by examination or other means of my physical or mental condition; and I hereby release them of any consequences thereof.

Dated at _____ am/pm this _____ day of _____, 20____.
TIME DATE MONTH

Witness

Patient Signature

PATIENT NAME: _____

ADDRESS: _____

DATE OF ACCIDENT: _____

TIME OF ACCIDENT: _____

Were you the: **DRIVER** **PASSENGER** **PEDESTRIAN**

If you were NOT the driver, who was? _____

Location of accident: _____

Was any information exchanged? Any information that you have will be helpful.

Insured: _____
NAME OF OTHER DRIVER

Insurance Company: _____
OTHER VEHICLE

Phone Number: _____

Adjuster: _____

Claim Number: _____

CONSENT TO TREATMENT OF A MINOR CHILD

I, _____ hereby consent to **Dr. Michael Goff**
(PRINT NAME OF PARENT/LEGAL GUARDIAN)

and his staff to treat _____ as he sees fit.
(PRINT NAME OF MINOR CHILD)

Signature of Parent/Legal Guardian

AUTHORIZATION FOR RELEASE OF RECORDS

PATIENT: _____

ADDRESS: _____

I hereby authorize _____ to disclose to
LOUISIANA HEALTH & INJURY CENTERS or their agents any information,
which he may have acquired by examination or other means of my physical or men-
tal condition; and I hereby, release him of any consequences thereof.

Dated at _____ this _____ day of _____, 20____.

TIME

DATE

MONTH

Patient Signature

Witness

Date of Birth

Date of Accident

Patient Social Security Number

Fax#