ADVANCED SPINE & REHAB / ADVANCED FAMILY HEALTHCARE
CONFIDENTIAL PERSONAL INJURY QUESTIONNAIRE & REGISTRATION FORM

This information is needed so we can better serve you. Please fill in ALL portions of the form. If one of the questions does not apply, please answer N/A and do not leave the line blank. If you need assistance, please ask one of our receptionists.

Patient Name: _____ E-mail: _____

SS# _____ Date of Birth: _____

Home #: (_____) _____Cell #: (_____) _____

Address: _____ City, State & Zip_____

Who referred you to our office? : _____

Employer Name: _____ Employer Phone: _____

Employer's Address: _____

Occupation: _____

Marital Status: _____ Spouse's Name: _____

Spouse SS #: _____ Spouse Date of Birth: _____ Spouse Employer: _____
Spouse Employer Phone #: _____ Spouse's Employer Address: _____
Spouse Occupation: _____

Emergency Contact Name: _____ Relationship to Patient: _____ Phone #: _____

Current Medication List (Including strength and dosage):

_____

_____

Medication Allergies:

_____

_____

Past Surgical History:

_____

_____

Accidents / Injuries ? _____

Have you ever been involved in any auto accidents before? *(Please circle one)* Yes / No

If yes, please list dates, type and injury received:

_____

_____

Have you had any hospitalizations in the last 5 years? *(If yes, please explain)*

_____

_____

List any previous illnesses, which relate to this case:

_____

_____

_____

Are you a diabetic? *(Please circle one)* Yes / No

Do you have high blood pressure? *(Please circle one)* Yes / No

Do you have low blood pressure? *(Please circle one)* Yes / No

Do you have arthritis or degenerative joint disease? *(Please circle one)* Yes / No

Have you seen anyone else for this condition? *(Please circle one)* Yes / No

If yes where? : _____ Phone #: _____

Did you have any physical complaints BEFORE the accident? _____

Accident Date: _____Time of Day: _____

City: _____ State: _____ County: _____

Were you the: ❑ DRIVER ❑ PASSENGER ❑ PEDESTRIAN

If passenger, were you in the: ❑ FRONT SEAT ❑ RIGHT REAR SEAT ❑ LEFT REAR SEAT

How many people were in the vehicle? _____

List the year, make, & model of the vehicle you were in: _____

List the year, make, & model of the OTHER vehicle: _____

The road conditions at time of accident? (*Circle all that apply):* ICY RAINY WET CLEAR DARK

Please describe the accident in your own words: _____

_____

_____

Illustrate below how the accident happened: *(Please draw what happened)*

Were the police notified? *(Please circle one)* Yes / No

Who was cited? _____

Did your vehicle strike the other vehicle? *(Please circle one)* Yes / No

Was your car struck by the other vehicle? *(Please circle one)* Yes / No

What direction was your vehicle going? _____

What direction was the other vehicle going? _____

Was the impact from: ❑ THE FRONT ❑ THE REAR ❑ THE LEFT-SIDE ❑ THE RIGHT-SIDE

What was the approximate speed at the time of impact? Your vehicle _____*mph* Other vehicle _____*mph*

Was your vehicle in: ❑ PARK ❑ NEUTRAL ❑ IN GEAR ❑ MOVING ❑ STOPPED

Were your brakes being applied? *(Please circle one)* Yes / No

Was your vehicle shoved: ❑ FORWARD ❑ BACKWARD ❑ SIDEWAYS

Were you shoved: ❑ FORWARD ❑ WHIPPED BACKWARD

Did the vehicle go into a spin or a roll as a result of the accident? (*Please circle one)* Yes / No

If yes, explain: _____

How much damage was there to the outside of your vehicle? ❑ NONE ❑ SOME ❑ A LOT

How much damage was there to the inside of your vehicle? ❑ NONE ❑ SOME ❑ A LOT

Did the seat break as a result of the impact? Yes / No

Were you wearing a seatbelt? Yes / No

Did the belt have a shoulder harness? Yes / No

If yes did it contribute to the pain you are experiencing? Yes / No

Is your car equipped with an airbag? Yes / No If yes, did it deploy? Yes / No

Did your seat have a head restraint (headrest)? Yes / No

If yes, what was the position? ❑ LOW ❑ MID-POSITION ❑ HIGH

How many inches from your head was the headrest on impact? _____

Did your head ride over the headrest? Yes / No

Did your hat/glasses end up in the back seat or rear window? Yes / No

At the time of impact were you:

❑ LOOKING STRAIGHT AHEAD ❑ LOOKING UP ❑ LOOKING DOWN

❑ LOOKING TO THE RIGHT ❑ LOOKING TO THE LEFT

Were you braced for the impact? Yes / No

Were you surprised by the impact? Yes / No

Were you holding on to the steering wheel? Yes / No

Did you brace your arms against the dash? Yes / No

Did you brace your legs against the floorboard? Yes / No

Was your ankle turned? Yes / No

At the time of the accident, recall what parts of your head or body hit what parts on the inside of the car:

_____

_____

Immediately after the accident, could you move all parts of your body? Yes / No

If, no what parts couldn't you move and why? _____

At the point of impact, where did you experience pain? Be specific:

_____

_____

Please describe how you felt during the accident?

_____

Were you able to get out of the car and walk unaided? Yes / No

If No, why? _____

Immediately after the accident were you: ❑ CONSCIOUS ❑ UNCONSCIOUS ❑ DAZED

If loss of consciousness, for how long? _____

Did you experience a flash of light or explosion in your head? Yes / No

Immediately after the accident, did you become?

❑ CONFUSED ❑ DISORIENTED ❑ LIGHT HEADED ❑ RINGING/BUZZING IN EARS

Since the accident, are your symptoms: ❑ BETTER ❑ WORSE ❑ SAME

Circle symptoms you have since the accident:

HEADACHE	HEAD SEEMS HEAVY	TROUBLE SLEEPING
NECK PAIN	STOMACH UPSET	RESTLESSNESS
PINS/NEEDLES IN ARMS	NECK STIFF	DIZZINES
PINS/NEEDLES IN LEGS	FAINTING	FORGETFULLNESS
NUMBNESS IN FINGERS	IRRITABILITY	FACE FLUSHED
NERVOUSNESS	SHORTNESS OF BREATH	FATIGUE
BACKPAIN	EYES SENSITIVE TO LIGHT	EARS RING
CHEST PAIN	LOSS OF BALANCE	LOSS OF MEMORY
DEPRESSION	LOSS OF TASTE	LOSS OF SMELL
COLD SWEATS	CONSTIPATION	FEET COLD
FEVER	DIARRHEA	HANDS COLD
REDUCED TOLERANCE TO ALCOHOL		
REDUCED TOLERANCE TO HEAT		
DIFFICULTY CONCENTRATING		

Symptoms other than listed above: _____

Did you get any bleeding cuts? Yes / No If yes, where? _____

Did you get any bruises? Yes / No If yes, where? _____

Did you go to the hospital? Yes / No If yes, which hospital? _____

If yes, when? ❑ RIGHT AFTER THE ACCIDENT ❑ NEXT DAY ❑ OTHER _____

If yes, how did you get there? ❑ AMBULANCE ❑ OTHER _____

If by ambulance, were you put into a: ❑ NECK BRACE ❑ BACK BRACE ❑ OTHER _____

Were there any medications or medical supplies given? Yes / No If yes, what? _____

Were x-rays taken? Yes / No

What type of treatment did you receive?

_____

Have you had any similar problems before? Yes / No If yes, explain:

_____

_____

Do you have any congenital (from birth) factors, which relate to this problem? Yes / No

If yes, please describe: _____

What type of work do you do? _____

What are your job requirements? _____

Have you lost any days of work from this injury? Yes / No If yes, please provide the dates:

_____

Are you being compensated for any time lost from work? Yes / No

If yes, what type of compensation?

_____

Do you notice any activity restrictions as a result of this accident? Yes / No

If yes, please describe in detail:

_____

_____

Other pertinent information:

_____

PATIENT'S PRINTED NAME _____ DATE_____

PARENT or LEGAL GUARDIAN'S PRINTED NAME _____DATE_____

PATIENT'S SIGNATURE (*if a minor, Parent or Legal Guardian Signature*)

_____

WITNESS NAME & SIGNATURE _____ DATE_____

PERSONAL INJURY VERIFICATION FORM

Patient Name: _____ DOB: _____

Date of Accident: _____ County:_____ City: _____ State: _____
Date of 1ST Visit:_____

PATIENT'S HEALTH INSURANCE INFORMATION

Insurance Company: _____ Insurance Ph. #: _____

Claims Address: _____

Subrogation? Y / N (*please circle*)

Policy Holder Name: _____ Policy Holder DOB: _____

Policy Holder SS#: _____ Policy ID #: _____ Group #: _____

PATIENT'S AUTO INSURANCE INFORMATION / MED PAY

Insurance Company: _____ Insurance Ph. #: _____

Claims Address: _____

MED PAY? Y / N (*please circle*)

Policy Holder Name: _____ Policy ID #: _____ Claim #: _____

Have you reported a claim? Y / N (*please circle*) Adjuster's Name: _____

AT-FAULT / THIRD PARTY INSURANCE INFORMATION

Responsible Party's Name: _____

Insurance Company: _____ Insurance Ph. #: _____

Claims Address: _____

Claim #: _____ Adjuster's Name: _____

ATTORNEY INFORMATION

Attorney's Name: _____ Ph. #: _____

Address: _____

Lien Filed: _____ Lien Sent: _____ Lien Received:_____ Records Mailed: _____

DATE	PHONE CALL LOG

ADVANCED SPINE & REHAB PC

NOTICE OF DOCTOR'S LIEN/ASSIGNMENT OF BENEFITS

Attorney:

Doctor's

Michael Crismon, DC
Stanley Miller, MD
Annette Lopez, FNP-C
4540 E Baseline Rd #111, Mesa, AZ 85206

Re: Doctor's and Medical Reports Lien for patient:_____

I do hereby authorize the above named doctor(s) to furnish you, my attorney, (or any person, firms, corporations, and their insurance carriers claimed to be liable for damages arising from the injuries for which I received care) with a full report of medical examination, diagnosis, treatment, prognosis, progress, and statement of fees of myself in regard to the accident / injury in which I was involved.

I hereby authorize and direct you, my attorney(s), to pay directly to said doctors such total sums as are currently due and may become due and owing him/her in the future for all medical and/or chiropractic and related services rendered me both by reason of this accident that are due his office and to further withhold such total sums from any settlement, judgment, court order or verdict as may be necessary to adequately protect and fully compensate said doctor for such total sums. I hereby further give a lien or assignment of my potential benefits on my pending / prospective case to said doctor against any and all proceeds of any settlement, judgement, or verdict which may be paid to you, my attorney, or myself as the results of the injuries for which I have been treated or injuries in connection there within.

I fully understand that I am directly and fully responsible to said doctor for all medical and/or chiropractic bills submitted by him for services rendered to me and that this agreement is made for said doctor's additional protection and in consideration of his awaiting payment and other services provided by him, as referenced above. I further understand that such payment is not contingent on any settlement, judgment, court order or verdict by which I may eventually recover said fee and that my doctor may take appropriate and timely action to enforce payment against me for all such outstanding medical and/or chiropractic bills.

I agree to promptly notify said doctor prior to any change or addition of attorney(s) used by me in connection with this accident, and I instruct my present attorney to do the same and to promptly deliver a copy of this lien to any such substituted or added attorney(s). I further acknowledge and agree that this executed lien/assignment shall be binding upon any subsequent and/or additional attorney(s) regardless of whether this written document is expressly acknowledged by such attorney.

I request that my attorney(s) and any applicable insurance company acknowledge this lien/assignment by signing below and returning to the doctor's office. The undersigned agrees that a copy of this lien may be forwarded to third parties responsible for payment to the patient and that such third parties can act directly in protecting such lien/assignment. Such insurance benefits shall include any coverages provided to the patient(s) for liability, disability, medical payments coverage, no-fault, health and accident, workers compensation and any other applicable benefits. Such insurers are directed and authorized to withhold and reimburse to my doctor such amount as necessary to satisfy the total sum owed by me for chiropractic services. The undersigned patient further acknowledges and agrees that in the event the enforceability and/or appropriate amount subject to this lien/assignment is litigated, the prevailing party will be awarded attorney's fees and costs.

This agreement shall be binding upon the patient's heirs, successors, personal representatives or assigns.

_____ _____

Patient's Signature *or* Dated
(Parent/Legal Guardian if Patient is Minor)

ACKNOWLEDGEMENT OF ATTORNEY

The undersigned, being attorney of record for the above patient (and/or insurance company representative), does hereby acknowledge receipt of this notice and hereby agrees to honor and comply with all the terms of the above agreement and agrees to protect adequately and/or otherwise withhold such sums from any settlement, judgment, court order or verdict as may be necessary to adequately protect and fully compensate said doctor above-named. Attorney and/or insurer further acknowledge that in the event the enforceability and/or appropriate amount subject to this lien/assignment is litigated, the prevailing party will be awarded attorney's fees and costs. This agreement shall be binding upon any successor, agent, representative, employee or substituted and/or added attorney(s) of the patient with the same force and effect. Any settlement of the claim without honoring this assignment/lien will cause you to be responsible to this office for payment. *(Under Arizona Revised Statutes # 33-931, Article 3-Health Care provider Liens)*

_____ _____

Attorney/Insurance Representative Signature Dated

Please date, sign and return one copy to doctor's office above. Also keep a copy for your records.