Chiropractic: • removes interference • restores function • maximizes potential • improves performance

PERSONAL INJURY REGISTRATION

If you need assistance completing this paperwork, just ask. It is our pleasure to help you.
We want your visit with us to be comfortable, helpful, and educational. confidential health information

1 MEMBER CONTACT

member id #: (office use only)	date

last name	first name	title (Mr., Mrs., Dr. Rev, ect.)
preferred name to be called	who referred you to our office?	
street address		
city	state	zip
home phone	mobile phone	
work phone	e-mail	

2 MEMBER PERSONAL

date of birth	number of children	male/female	☐single ☐married ☐partnered ☐ widowed ☐separated ☐ divorced

3 EMERGENCY CONTACT

name	home phone
relationship	work phone

4 MEMBER EMPLOYMENT

employer name	occupation		
street	city	state	zip

Today we will conduct a thorough history, consultation, and preliminary screening. If we believe we can help you, we may recommend other diagnostic testing necessary to evaluate your condition. If we believe that you will not respond to our care, we will not accept your case and may refer you to another provider.

I understand and agree to the following:
- A history, consultation, examination, and x-rays are conducted for diagnostic and informational purposes. I am requesting these services.
- My case may not be accepted for care at this office.
- If the doctors believe that I may respond to their care, additional service may be recommended and I will be advised of applicable cost.

✗

member or guardian **signature** date

5 MEMBER HISTORY

height	weight
how much weight have you lost in the past year?	how much weight have you gained in the past year?

6 PREGNANCY (WOMEN ONLY)

X-Rays are contraindicated during pregnancy. This clinic does not knowingly x-ray women who are or may be pregnant regardless of stage or trimester of pregnancy. If there is a chance that you may be pregnant let the doctor or assistant know right now.

Are you pregnant?	☐ yes	☐ no	On what date did your last period begin?
Tubal ligation?	☐ yes	☐ no	
Hysterectomy?	☐ yes	☐ no	✗ member or guardian **signature** date

member name:

AREAS OF COMPLAINT: place an X in the boxes that apply

7 NECK

Have you experienced any problems like these recently or in the past?

☐headaches ☐ear infections ☐sinus problems
☐ringing in the ears ☐dizziness ☐vision difficulties
☐allergies ☐chronic coughing ☐memory loss

The nerves in your neck control things like eyes, ears, nose, throat, and brain function. If there is a problem (subluxation) in your neck it is common to experience things like these and we may be able to help you.

Are you experiencing symptoms like these lately?

☐neck pain ☐ear infections ☐sinus problems
☐ringing in the ears ☐dizziness ☐vision problems

A subluxation can also affect all the muscles around your neck, across your shoulders, and down your arms to the tips of your fingers. So, if you have a subluxation in your neck it is common to experience symptoms like these and we can help you.

8 LOW BACK

Have you experienced any problems like these recently or in the past?

☐constipation ☐diarrhea ☐gas/bloating
☐urinary control problems ☐urinary tract infections
☐bladder stones ☐kidney stones

Female: ☐painful PMS symptoms ☐ectopic pregnancies
☐problems with menopause

Male: ☐difficult urination (prostate) ☐sexual dysfunction

This area controls your bowel, bladder, and reproductive system. If there is a subluxation in this area it is common to experience things like these.

Are you experiencing symptoms like these lately?

☐low back pain ☐deep pain in your buttocks/thighs
☐burning sensations down your legs
☐pain or tingling from your legs down to your toes
☐cramping or twitching of your muscles
☐circulation problems in your feet

As you can tell subluxation can also affect the nerves in this area and leads to more serious problems like tingling, numbness in muscles, muscle spasm, pain and even muscle weakness / paralysis. So, if you have a subluxation in this area we will discuss your treatment options and help you.

9 MID BACK

Have you experienced any problems like these recently or in the past?

☐heart arrhythmia ☐heart palpitations ☐heart attacks
☐difficulty breathing ☐asthma ☐bronchitis
☐pneumonia ☐indigestion ☐reflux ☐ulcers
☐hyperglycemia ☐hypoglycemia ☐get sick easily
☐high blood pressure ☐low blood pressure

Your brain and spinal cord controls things like the heart, lungs, stomach, liver, kidneys and gland function. If there is a subluxation in your spine it can impair your body's ability to function properly.

Are you experiencing symptoms like these lately?

☐mid back pain ☐pain in the ribs
☐burning sensations along a rib
☐pain with deep breathing
☐stabbing pain between shoulder blades

10 INJURIES

List any auto collisions, falls, impacts or sports injuries you may have experienced.

type of collision / injury / surgery	type of treatment received	date of injury
1.		
2.		
3.		

11 MEDICATIONS

List any prescription or over-the-counter medications you are currently taking.

medications	reason	medication	reason
1.		3.	
2.		4.	

12 HEALTH HISTORY

Mark the conditions as they pertain to you and your immediate family.
n = never p = previous c = current

YOU		FAMILY MEMBERS			
n p c	Diabetes	n p c mother	n p c father	n p c brother	n p c sister
n p c	Heart problems	n p c mother	n p c father	n p c brother	n p c sister
n p c	Kidney problem	n p c mother	n p c father	n p c brother	n p c sister
n p c	Cancer	n p c mother	n p c father	n p c brother	n p c sister
n p c	Back pain	n p c mother	n p c father	n p c brother	n p c sister

I understand and agree to the following:

- A history, consultation, examination, and x-rays are conducted for diagnostic and informational purposes. I am requesting these services.
- It is my responsibility to complete this office's forms accurately.
- It is my responsibility to notify the doctor if any of my information requires updating.
- All original information including X-rays are the office's property and copies of my file may be released to me for a nominal fee.

✘

member or guardian **signature** date

PERSONAL INJURY QUESTIONNAIRE

Name____Phone (   )_____________________________

Address _____________________________________   City ______________________ State_______   Zip _________

Age _________ Birth date ______________________   Sex____________   SS #_____________________________

Employer's Name ____________________________   Employer's Address ___________________________________

Your Ins. Co. _________________________________   Policy # __________________   Agent's Name ______________

Name on Policy (if other than self) ____   Policy # ___________________

Responsible Party's Name: ____

Address _____________________________________   City ______________________ State_______   Zip _________

Policy Holder's Name _________________________________   Policy # _______________________________________

ATTORNEY

Name____Phone (   )_____________________________

Address ____________________________________   City ______________________ State_______   Zip _________

Were there any witnesses (   ) Yes   No (   ) Name(s)____

NATURE OF ACCIDENT

1. Date of Accident _______________   Time of Day _______________
2. Were you: (   ) Driver   (   ) Passenger   (   ) Front Seat   (   ) Back Seat
3. Number of people in your vehicle _______ Were you wearing seat belts? (   ) Yes   (   ) No
4. What direction were you headed? (   ) North (   ) East (   ) South (   ) West
   on (name of street) ____
5. What direction was the other vehicle headed? (   ) North   (   ) East   (   ) South   (   ) West
   on (name of street) ____
6. Were you struck from: (   ) Behind   (   ) Front   (   ) Left Side   (   ) Right Side
7. Approximate speed of your car __________ mph   Other car __________ mph
8. Were you knocked unconscious? (   ) Yes   (   ) No   If yes, for how long? __________________________________
9. Were the police notified? (   ) Yes   (   ) No
10. In your own words, please describe the accident:
    ____
    ____
    ____
11. Did you have any physical complaints BEFORE THE ACCIDENT? (   ) Yes (   ) No   If yes, please describe in detail:
    ____
    ____
    ____
12. Please describe how you felt:
    a. DURING the accident: ____
    b. IMMEDIATELY AFTER the accident ____
    c. LATER THAT DAY: ____
    d. THE NEXT DAY: ____

13. What are your PRESENT complaints and symptoms?
____
____

14. Do you have any congenital (from birth) factors which relate to this problem? ( ) Yes ( ) No if yes, please describe
____

15. Do you have any previous illnesses which relate to this case? ( ) Yes ( ) No if yes, please describe
____

16. Have you ever been involved in an accident before? ( ) Yes ( ) No if yes, please describe
____
____

17. Where were you taken after the accident? ____

18. Have you been treated by another doctor since the accident? ( ) Yes ( ) No if yes, please list doctor's name and address: ____
What type of treatment did you receive?
____

19. Since this injury occurred, are your symptoms: ( ) Improving ( ) Getting Worse ( ) Same

20. CIRCLE SYMPTOMS YOU HAVE NOTICED SINCE THE ACCIDENT:

Headache	Irritability	Numbness in Toes	Face Flushed	Feet Cold
Neck Pain	Chest Pain	Shortness of Breath	Buzzing in Ears	Hands Cold
Neck Stiff	Dizziness	Fatigue	Loss of Balance	Stomach Upset
Sleeping Problems	Head Seems Too Heavy	Depression	Fainting	Constipation
Back Pain	Pins & Needles in Arms	Lights Bother Eyes	Loss of Smell	Cold Sweats
Nervousness	Pins & Needles in Legs	Loss of Memory	Loss of Taste	Fever
Tension	Numbness in Fingers	Ears Ring	Diarrhea	

Symptoms Other Than Above ____

21. Have you lost time from work as a result of this accident? ( ) Yes ( ) No if yes, please complete this question.
    a. Last Day Worked:____
    b. Type of Employment: ____
    c. Present Salary: ____
    d. Are you being compensated for time lost from work? ( ) Yes ( ) No if yes, please state type of compensation you are receiving: ____________________________________

22. Do you notice any activity restrictions as a result of this injury? ( ) Yes ( ) No if yes, please describe, in detail:
____
____
____

23. Other pertinent information: ____
____
____
____

______________________________ ______________________________________

Date Patient's Signature

Patient Name: ______________________________________ Date____________

Present Complaint - *What brings you in the office today?*

Mark your areas of pain on the figure Below

1 *Primary Complaint:(Where do you hurt?)*

How long have you been experiencing this primary complaint?

Describe any recently related accident or fall:

How often do you experience symptoms? (check only one)

- ☐ Constant 100% ☐ Frequent 75%
- ☐ Intermittent 50% ☐ Occasional 25%
- ☐ Daily ☐ Weekly ☐ Monthly ☐ yearly

What makes the symptoms worse?

What gives relief of symptoms?

How does the primary complaint feel:

- ☐ Sharp ☐ Dull/achy ☐ Tingling ☐ Burning
- ☐ Throbbing ☐ Numbness ☐ Stabbing ☐ Cold

Where does the pain radiate to?

Does it wake you up at night? Y N

A = ACHE
P = PINS & NEEDLES
B = BURNING
S = STABBING
N = NUMBNESS
O = OTHER

Left _______ Right ______

How bad is your pain? (indicate 0 no pain - 5 pain prevents my daily activity - 10 unbearable/bed ridden)

Mild 0 -------------------------- 5 ---------------------------- 10 Severe

The symptoms I experience make it difficult to:			☐ **sleep**	☐ **carry objects**	☐ **move arms/legs**
☐ **short walk**	☐ **long walk**	☐ **twist**	☐ **lift**	☐ **bend**	☐ **use bathroom**
☐ **shower**	☐ **clean house**	☐ **do dishes**	☐ **vacuum**	☐ **enjoy life**	☐ **enjoy spouse**

Mark your areas of pain on the figure Below

2 *Secondary Complaint:(what else bothers you?)*

How long have you been experiencing this primary complaint?

Describe any recently related accident or fall:

How often do you experience symptoms? (check only one)

- ☐ Constant 100% ☐ Frequent 75%
- ☐ Intermittent 50% ☐ Occasional 25%
- ☐ Rare 10%

What makes the symptoms worse?

What gives relief of symptoms?

How does the secondary complaint feel:

- ☐ Sharp ☐ Dull/achy ☐ Tingling ☐ Burning
- ☐ Throbbing ☐ Numbness ☐ Stabbing ☐ Cold

Where does the pain radiate to?

Does it wake you up at night? Y N

A = ACHE
P = PINS & NEEDLES
B = BURNING
S = STABBING
N = NUMBNESS
O = OTHER

Left _______ Right ______

How bad is your pain? (indicate 0 no pain - 5 pain prevents my daily activity - 10 unbearable/bed ridden)

Mild 0 -------------------------- 5 ---------------------------- 10 Severe

PATIENT'S NAME: ____ HR#: _____________ DATE: ___________

ACTIVITIES OF LIFE

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:

ACTIVITIES:	**EFFECT:**			
Carry Children/Groceries	O No Effect	O Painful (can do)	O Painful (limits)	O Unable to Perform
Sit to Stand	O No Effect	O Painful (can do)	O Painful (limits)	O Unable to Perform
Climb Stairs	O No Effect	O Painful (can do)	O Painful (limits)	O Unable to Perform
Pet Care	O No Effect	O Painful (can do)	O Painful (limits)	O Unable to Perform
Extended Computer Use	O No Effect	O Painful (can do)	O Painful (limits)	O Unable to Perform
Lift Children/Groceries	O No Effect	O Painful (can do)	O Painful (limits)	O Unable to Perform
Read/Concentrate	O No Effect	O Painful (can do)	O Painful (limits)	O Unable to Perform
Getting Dressed	O No Effect	O Painful (can do)	O Painful (limits)	O Unable to Perform
Shaving	O No Effect	O Painful (can do)	O Painful (limits)	O Unable to Perform
Sexual Activities	O No Effect	O Painful (can do)	O Painful (limits)	O Unable to Perform
Sleep	O No Effect	O Painful (can do)	O Painful (limits)	O Unable to Perform
Static Sitting	O No Effect	O Painful (can do)	O Painful (limits)	O Unable to Perform
Static Standing	O No Effect	O Painful (can do)	O Painful (limits)	O Unable to Perform
Yard work	O No Effect	O Painful (can do)	O Painful (limits)	O Unable to Perform
Walking	O No Effect	O Painful (can do)	O Painful (limits)	O Unable to Perform
Washing/Bathing	O No Effect	O Painful (can do)	O Painful (limits)	O Unable to Perform
Sweeping/Vacuuming	O No Effect	O Painful (can do)	O Painful (limits)	O Unable to Perform
Dishes	O No Effect	O Painful (can do)	O Painful (limits)	O Unable to Perform
Laundry	O No Effect	O Painful (can do)	O Painful (limits)	O Unable to Perform
Garbage	O No Effect	O Painful (can do)	O Painful (limits)	O Unable to Perform
Driving	O No Effect	O Painful (can do)	O Painful (limits)	O Unable to Perform
Other: _________________	O No Effect	O Painful (can do)	O Painful (limits)	O Unable to Perform

List Prescription & Non-Prescription drugs you take: ____

____

____

___________________________________ ______ - ______ - ______

Patient or Authorized Person's Signature **Date Completed**

___________________________________ ______ - ______ - ______

Doctor's Signature **Date Form Reviewed**

Continued on next page/reverse side

QUADRUPLE VISUAL ANALOGUE SCALE

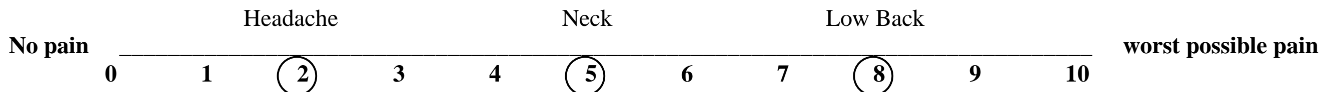
Patient Name ____ Date __________________________

Please read carefully:

Instructions: Please circle the number that best describes the question being asked.

Note: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your pain level right now, average pain, and pain at its best and worst.

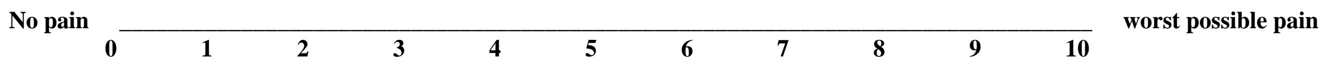
Example:

No pain 

worst possible pain

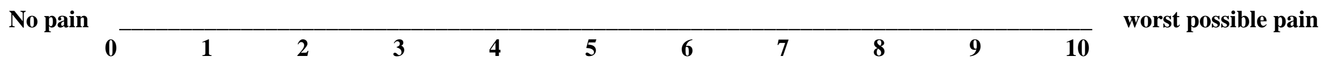
---

1 – What is your pain RIGHT NOW?

No pain 

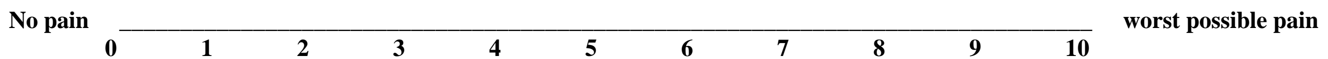
worst possible pain

2 – What is your TYPICAL or AVERAGE pain?

No pain 

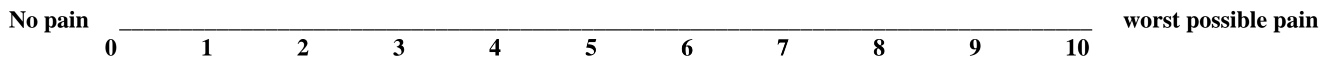
worst possible pain

3 – What is your pain level AT ITS BEST (How close to "0" does your pain get at its best)?

No pain 

worst possible pain

4 – What is your pain level AT ITS WORST (How close to "10" does your pain get at its worst)?

No pain 

worst possible pain

OTHER COMMENTS:

____

____

____
Examiner

Reprinted from *Spine*, 18, Von Korff M, Deyo RA, Cherkin D, Barlow SF, Back pain in primary care: Outcomes at 1 year, 855-862, 1993, with permission from Elsevier Science.

OFFICE OF INSURANCE REGULATION
Bureau of Property & Casualty Forms and Rates

Standard Disclosure and Acknowledgement Form
Personal Injury Protection - Initial Treatment or Service Provided

The undersigned insured person (or guardian of such person) affirms:

1. The services or treatment set forth below were **actually rendered.** This means that those services have **already been provided.**

   Chiropractic
   Xrays

2. I have the right and the **duty to confirm** that the services have already been provided.
3. I was **not solicited** by any person to seek any services from the medical provider of the services described above.
4. The medical provider has **explained** the services to me for which payment is being claimed.
5. If I notify the insurer in writing of a billing error, I may be entitled to a portion of any reduction in the amounts paid by my motor vehicle insurer. If entitled, my share would be at least 20% of the amount of the reduction, up to $500.

Insured Person (patient receiving treatment or services) or Guardian of Insured Person:

Name *(PRINT or TYPE)* ________ Signature ________ Date ________

The undersigned licensed medical professional or medical director, if applicable, affirms the statement numbered 1 above and also:

A. I have **not solicited** or caused the insured person, who was involved in a motor vehicle accident, to be solicited to make a claim for Personal Injury Protection benefits.

B. The treatment or services rendered were explained to the insured person, or his or her guardian, **sufficiently** for that person to sign this form with informed consent.

C. The accompanying statement or bill is **properly completed** in all material provisions and all relevant information has been provided therein. This means that each request for information has been responded to **truthfully, accurately**, and in a **substantially complete** manner.

D. The coding of procedures on the accompanying statement or bill is proper. This means that **no service has been upcoded, unbundled**, or constitutes an invalid **or not medically necessary diagnostic test** as defined by Section 627.732(14) and (15), Florida Statutes or Section 627.736(5)(b)6, Florida Statutes.

Licensed Medical Professional Rendering Treatment/Services or Medical Director, if applicable *(Signature by his/ her **own hand**):*

Kevin Kustarz D.C.
Name *(PRINT or TYPE)* ________ Signature ________ Date ________

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of Claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree per Section 817.234(1)(b), Florida Statutes.

Note: The **original** of this form must be furnished to the insurer pursuant to Section 627.736(4)(b), Florida Statutes and may **not** be electronically furnished. Failure to furnish this form may result in non-payment of the claim.

True Vine Chiropractic

PIP Insurance Verification

TAX ID: **NPI:**

Date:____________________Verified By:_____________________With:_________________________

Patient Name:____DOB:_________________________

Insured Name:____DOB:_________________________

Relation to Insured: Self Spouse Child Other:_________________________

Insurance Company:________________________________Phone #:_________________________

Claims Address:____

Policy #:______________________________Claim #:_______________________________________

Date of Accident:______________________

Adjustor

Name:____Ext. _________________

Benefits:___________Basic PIP: Y N Deductible:_______________Met:_________________

Med Pay: Y N $

Does Patient Have Health Insurance: Y N

True Vine Chiropractic
<u>Assignment of Benefits Form</u>

<u>POWER OF ATTORNEY TO ENDORSE CHECKS AND/OR TO SIGN ANY PAPER WHICH WILL ENHANCE OR EXPEDITE PAYMENT TO PROVIDER FOR SERVICE RENDERED, INCLUDING BUT NOT LIMITED TO A RELEASE OF MEDICAL RECORDS AND ASSIGNMENT OF BENEFITS/AUTHORIZATION TO PAY.</u>

Known by all these present that: the undersigned has made, constituted and appointed, and by these presents does hereby make, constitute and appoint TRUE VINE CHIROPRACTIC, PA and any of its duly authorized agents and employees as and to be the undersigned's true and lawful attorney for and in the undersigned's name, place and stead to endorse any and all checks, drafts or money orders which are made payable to the undersigned alone or to the undersigned and TRUE VINE CHIROPRACTIC, PA which checks, drafts or money orders are made payable for services which have been made by TRUE VINE CHIROPRACTIC, PA at the request of with the knowledge and approval of the undersigned and/or maker of the check, draft or money order.

This assignment includes but is not limited to, all rights to collect benefits directly from my insurance company for services that I have received and all rights to proceed against my insurance company in any action including legal suit if for any reason my insurance company fails to make payments of benefits due to my assignee or me. This assignment also includes any rights to recover attorney's fees and costs for such action brought by the provider as my assignee.

The undersigned by these presents does give and grant TRUE VINE CHIROPRACTIC, PA as attorney the full power and authority to do and perform all and every act whatsoever requisite and necessary to be done in and about the premises as fully to all intents and purposes as the undersigned might or could do to personally present insofar as the endorsing and cashing of said check and concerned as well as any other document.

At any time after Insurer fails to render the applicable payment within 30 days upon receipt of Health Care Providers medical bills got any date of service, this agreement may be revoked. Health Care Provider's said revocation will be effective on the thirty first (31) day after Insurer has received Health Care Provider medical bill(s) that Insurer has denied, withdrawn, reduced, or failed to pay in accordance with Florida Statutes 627.736. Said revocation shall include any and all dates of services subsequent to the thirty-first (31) day after Insurer has received Health Care Provider medical bills that Insurer has denied, withdrawn, reduced, or failed to pay in accordance with Florida Statute 627.736.

A photocopy of this document shall be as binding as an original signature page.

The undersigned does hereby ratify and confirm any and all actions taken by the said attorney in accordance with this special power and which the said attorney shall do cause to be done by virtue of these presents.

<u>ASSIGNMENT OF BENEFITS</u>

I,____________________________, hereby authorize ____________________________________
(name of insured) (name of insurance company)

to pay to and mail directly to TRUE VINE CHIROPRACTIC, PA the medical benefits otherwise payable to me for their services, but not to exceed the charges of those services. I hereby irrevocably assign to TRUE VINE CHIROPRACTIC, PA and benefits under any policy of insurance, indemnity agreement, or any other collateral source as defined in Florida Statutes for any services and charges provided by TRUE VINE CHIROPRACTIC, PA.

_________________________________ ___________________________ ____________

PRACTICE MEMBER'S SIGNATURE PRACTICE MEMBER'S NAME DATE

Request for Release of PIP Benefit Information

Re: Claim #:____________________

Policy #:____________________

Name if Insured:______________________________________

Dear Agent of________________________________Insurance Company,

I,__________________________request that you release any and all pertinent information regarding benefits under the aforementioned claim/policy number to True Vine Chiropractic, where I am seeking treatment for my injuries sustained in the automobile accident on _____/_____/_____. Should you require further information please contact me at (____)_____-_____ , or a staff member of True Vine Chiropractic at (561) 427.7720. Thank you for your prompt attention to this matter.

Sincerely,

____ ________________

Signature Date