

PERSONAL INJURY QUESTIONNAIRE Non- Automobile or Workers Compensation

Please answer all of the following questions completely.

1. Name _____
2. Address _____
City, State, Zip _____
3. Phone Number: Home _____ Work _____
4. Please describe the injury in your own words:

5. Was there anything in particular that you think caused the injury: example: wet floor
Please Describe _____

6. Where did the injury occur? _____
7. City/Town: _____ State: _____ Telephone # _____
8. Date of injury: _____ Time: _____ AM PM
9. Did anyone witness your injury? Yes No Who? _____
10. Did you report the injury to anyone Yes No To Whom? _____
11. Was the report written verbal
12. Have you retained an attorney No
13. If Yes, please give name and address: _____

14. Immediately after the injury were you: conscious dazed unconscious
15. If you lost consciousness, how long? _____
Did you go to the hospital? Yes No
16. If yes, when? right after the injury next day other _____
Name of hospital _____ Name of doctor _____
Diagnosis _____
Treatment Received _____
17. If yes, how did you get there? ambulance other: _____
18. If by ambulance, did the ambulance attendants place you in a: neck brace
 back brace other _____
19. Was any medication or medical supplies given? Yes No If yes, list:

20. Did you have x-rays taken at the hospital? Yes No
21. Are you diabetic? Yes No
22. Do you have high blood pressure? Yes No
23. Do you have arthritis or degenerative joint disease? Yes No
24. List all prescription and non prescription medications you take on a regular basis:

25. Are you presently under treatment for any condition? Yes No _____

26. Who is your primary care doctor: name, address and phone: _____

27. Do You Smoke? Yes No Drink Alcohol? Yes No

28. Did you have any physical complaints **Just before the injury?** Yes No

29. If yes, what physical symptoms did you have **just before the injury?** _____

30. What type of work do you do? _____

31. What are your job requirements? _____

32. Have you lost any days of work because of this injury? Yes No

33. If yes, give dates: _____

ACTIVITIES OF DAILY LIVING

34. Do you notice any of your **HOME** activities that are different **now** from than **before** the injury? No. If YES, list them as: (please be very specific)

Those activities that you are now unable to do are: _____

Those activities that are now painful to do are: _____

Those activities that are now difficult to do are: _____

Is there anything else we should know? _____

Patient Signature _____ Date _____

Print Name _____

PERSONAL INJURY INSURANCE COVERAGE

Pt. Name: _____ Number _____ Date _____
Insurance Company _____
Address _____
Name of adjuster handling claim _____
Spoke With _____ Time: _____ AM / PM
Phone Number _____ Date of Accident _____
Insured Name _____
Claim Number _____ Policy Number _____
Has the accident been reported? Yes No
Will company accept assignment of benefits? Yes No
If not, will they make checks payable to patient and our practice? Yes No
Limits: How much? \$ _____ What's left? _____

GROUP HEALTH INSURANCE

Your Medical insurance Company: _____
Address _____
Phone Number _____ Policy# _____
Insured Name _____
Agent _____ Phone _____

ATTORNEY INFORMATION

Date _____ Spoke With _____ Number _____
Patient Name _____
Attorney Name _____
Address _____
Phone Number _____
Does attorney need copies of bills? Yes No
In the event of settlement, will they protect any unpaid balance? Yes No
Do they have PIP? Yes No Do we file? Yes No
Do they have insurance? Yes No Do we file? Yes No
Can we file liability? Yes No

PATIENT RECORDS AND DOCTOR'S LIEN

TO: ATTORNEY/INSURANCE CARRIER

I do hereby authorize the above provider to furnish you, my attorney/insurance carrier, with a full report of his/her case history, examination, diagnosis, treatment, and prognosis of myself in regard to my injury/illness which occurred/began on:

I hereby give a lien to said provider on any settlement, judgment, or verdict as a result of said injury/illness, and authorize and direct you, my attorney/insurance carrier, to pay directly to said provider such sums as may be due and owing him/her for services rendered me, and to withhold such sums from such settlement, claim, judgment or verdict as may be necessary to protect said provider adequately.

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

I further agree to be fully responsible for reasonable attorney's fees and costs that have accrued due to the pursuance of payment of my account. Also, that in the event of noncompliance to payment agreement I understand the amount of balance due will be subject to a 1% per month service charge.

Patient's Signature: _____ Dated: _____

The undersigned, being attorney of record or authorized representative of insurance carrier for the above patient does hereby acknowledge receipt of the above lien, and does agree to honor the same to protect adequately the above named provider.

Attorney's Signature: _____ Dated: _____

Please sign, retain a copy for your records, and return this copy to us promptly.