

Patient Registration for Motor Vehicle Accidents

The information you provide is confidential and will not be reproduced or shared without your permission unless permitted by law.

First name _____ MI _____ Last name _____

Gender _____ Birth date _____ Drivers license # _____ State: _____

Home address _____ City _____ State _____ Zip _____

Home phone # _____ Mobile /Voice mail # _____

Your occupation _____ Your work status [circle one] Full time Part time

Your employer _____ Work phone # _____

Employer address _____ City _____ State _____ Zip _____

[circle one] Spouse, Partner or Parent name _____ Their phone # _____

Emergency contact person _____ Their phone # _____

Who referred you or how did you hear about this office? _____

Who is filling out this questionnaire? _____ Relationship to patient: _____

Day and date of the accident _____ Time of the accident _____ AM / PM

Where did the accident happen? _____

Was an accident report filed? [circle one] No Yes **Please allow us to copy the report and include it in your file.**

Describe the accident in your own words: _____

Were you the: [circle one] Driver Passenger/Front Passenger/Rear Pedestrian Bicyclist Other: _____

Describe your vehicle: [circle one] Auto Truck SUV Van Motorcycle Bicycle Other: _____

Make _____ Model _____ Year _____ Estimated damage \$ _____

Were you or your vehicle struck by another vehicle? [circle one] No Yes

Did your vehicle strike another vehicle? [circle one] No Yes **What part of that vehicle did you hit?** _____

Describe the other vehicle: [circle one] Auto Truck SUV Van Motorcycle Bicycle Other: _____

Make _____ Model _____ Year _____ Estimated damage \$ _____

Did your vehicle strike a stationary object? [circle one] No Yes **What did you hit?** _____

Were you wearing a safety restraint? [circle all that apply] No Yes *Shoulder harness Lap belt Child's car safety seat*

Did the safety restraint hold during the impact? [circle one] No Yes Does not apply

Was there a headrest on your seat? [circle one] No Yes Does not apply

Did your head strike the headrest at the time of impact? [circle one] No Yes Does not apply

Did you have both hands on the steering wheel? [circle one] No Yes Does not apply

Did you have your foot on the brake? [circle one] No Yes Does not apply

Were you braced for the impact? [circle one] No Yes Does not apply

Which direction were you looking at the time of impact? [circle all that apply] *Straight-ahead Right Left Up Down*

At the moment of impact did you try to grab anything or restrain anyone? [circle one] No Yes *Describe what you did:*

What was your speed or your vehicle's approximate speed at impact? _____

What was the approximate speed of the other vehicle at impact? _____

After the accident were you unconscious? [circle one] No Yes Were you dazed or disoriented? [circle one] No Yes

Describe how you felt immediately after the accident: _____

On the following pain scale diagram, circle the number from 0 to 10 that best represents the level of pain you felt immediately following the accident:

No pain = 0 1 2 3 4 5 6 7 8 9 10 = Incapacitating pain

List and describe the parts of your body that were injured or cause you pain as a result of this accident, *including all bumps, bruises, broken bones, cuts, scrapes, scratches, or marks left by your seat belt.*

Did you receive medical attention at the scene? [circle one] No Yes

Were you taken to a hospital? [circle one] No Yes *Name of hospital* _____

What did you do after the accident or hospital? [circle one] Went home Went to work Went to a doctor Resumed Activities

Has another doctor treated you since the accident or hospital? [circle one] No Yes *Still treating?* [circle one] No Yes

Doctor's Name _____ [circle one] MD DO DC ND Phone # _____

Address or location where you were treated _____

Dates you were treated _____ Diagnosis _____

Have x-rays or MRI films been taken for your current condition? [circle one] No Yes *When?* _____

What other tests have been done to diagnose or monitor your current condition? _____

When? _____

Are you taking any prescription medications for your injuries or discomfort? [circle one] No Yes

Please list the names of those prescription medications you are currently taking. Be sure to indicate the dosage or how much you take and how often you take it:

1. _____ 2. _____

3. _____ 4. _____

Describe your symptoms from the day after the accident until today: _____

On the following pain scale diagram, circle the number from 0 to 10 that best represents the typical level of pain you have felt from the day after the accident until today.

No pain = 0 1 2 3 4 5 6 7 8 9 10 = Incapacitating pain

Were you involved in any prior auto accidents? [circle one] No Yes *In what month and year?* _____

Were you ever treated for a work related injury? [circle one] No Yes *In what month and year?* _____

Did you have any physical complaints caused by a prior accident that were bothering you before this accident or that are worse after this accident? [circle one] No Yes

Please describe: _____

Did you have any other physical complaints before this accident? [circle one] No Yes

Please describe: _____

Before the accident were you capable of working on an equal basis with others your age? [circle one] No Yes

Are your work activities restricted as a result of this accident? [circle one] No Yes

Are your home activities restricted as a result of this accident? [circle one] No Yes

Signature _____

Date _____

Insurance Registration for Motor Vehicle Accidents

The information you provide is confidential and will not be reproduced or shared without your permission unless permitted by law.

First name _____ MI _____ Last name _____

Gender _____ Birth date _____ Drivers license # _____ State: _____

Day and date of the accident _____ Time of the accident _____ AM / PM

Where did the accident happen? _____

*Liability insurance in Oregon is based on a form of no-fault law. This means, the company that insures **the vehicle you were in during the accident** will pay for your medical expenses no matter who was at fault. The no-fault portion of your vehicle's insurance policy is called PIP or Personal Injury Protection. We do not accept cases that refuse to file a PIP claim.*

Your vehicle insurance company name _____

Are you the insured? [circle one] Yes No If No, insured's name _____

Your relationship to the insured [circle one] SELF SPOUSE CHILD OTHER: _____

Insurance Claim # for medical expenses _____

Name of Claim Rep or Adjuster _____ Phone # _____

Did you file an Application for Medical (PIP) Benefits? [circle one] Yes No Date filed _____

Did you accept payment or a settlement from the at-fault party? [circle one] Yes No Date accepted _____

Automobile accidents involve both medical and legal issues. You need to know your rights in order to protect your claim. We will inform you of our policies and share our experience in dealing with insurance issues. However, you should obtain qualified legal advice if you have questions about your rights and responsibilities under Oregon law.

Many patients retain a personal injury attorney to handle their claim. If your insurance company refuses to pay for your reasonable and necessary medical expenses, we may ask you to retain an attorney in order to protect your claim.

Name of Attorney _____ Phone # _____

Your health care providers will send your bills for medical expenses to your automobile insurance company. They will not send bills to a third party or to your health insurance. All bills will be in the form of "clean claims." This means your bills will conform to industry standards and contain all necessary documentation to establish medical necessity and facilitate timely reimbursement. All charges for your services will be based on the Oregon Medical Fee and Payment Rules; this is the legal standard that your health care providers and your insurance company must follow when submitting and paying PIP claims.

Your providers will make all reasonable efforts to obtain payment in a timely manner directly from your insurance company. However, they cannot negotiate on your behalf regarding your insurance policy provisions or your legal rights. If your medical expenses are not paid by your insurance company, you will be billed directly for the unpaid charges and under the terms of your signed Financial Agreement, you must pay your provider.

Signature _____

Date _____

Health History

The information you provide is confidential and will not be reproduced or shared without your permission unless permitted by law.

Personal History

Name _____ Date of Birth _____ Age _____

[circle one] Right handed Left handed Ambidextrous Your HEIGHT: _____ feet _____ inches

Your current WEIGHT: _____ pounds Your normal WEIGHT: _____ pounds

Have you recently gained or lost a significant amount of weight? [circle one] Yes No If YES, how much and over what time period? _____

Female patients, please answer the following questions:

Are you pregnant, or do you have any reason to believe that you could be pregnant? [circle one] Yes No

Number of children _____ Number of pregnancies _____ Number of births _____

Social History Please check the appropriate column if any of the following apply to you:

| PAST | PRESENT | | |
|--------------------------|--------------------------|------------------------------|---------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Tobacco | Per day _____ or per week _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Alcohol | Per day _____ or per week _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Caffeinated drinks | per day _____ or per week _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Decaffeinated coffee | per day _____ or per week _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Drugs and related substances | |

Past Health History

PRIOR INJURIES

Please list all major past injuries, even if you never received medical care

INJURY DATE OCCURRED WORK RELATED [yes or no] DOES THE CONDITION RECUR [yes or no]

PRIOR ADULT ILLNESSES

Please list all serious illnesses, such as ASTHMA, CANCER, DIABETES, HEART DISEASE, HEPATITIS, HIGH BLOOD PRESSURE, HIV INFECTION, SEIZURES, SICKLE CELL ANEMIA, TUBERCULOSIS.

DATE DIAGNOSIS TREATMENT GIVEN ANY REMAINING PROBLEMS?

PRIOR SURGERIES & HOSPITALIZATIONS

Please list all major surgeries/ operations and times you were hospitalized, even if you never had surgery

DATE TYPE OF SURGERY OR CAUSE OF HOSPITALIZATION ANY COMPLICATIONS? ANY REMAINING PROBLEMS?

Family History Please tell us about your birth parents and blood relatives if this information is available to you

Mother is [circle one] LIVING DECEASED Age _____ Cause of death _____

Father is [circle one] LIVING DECEASED Age _____ Cause of death _____

Please check the appropriate column if any of the following apply now or in the past to your blood relatives

- | | |
|--|---|
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Diabetes mellitus |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Anemia, blood, bleeding disorders | <input type="checkbox"/> Inherited disorder _____ |

Your Symptoms List Please check the appropriate column for symptoms you have experienced before (PAST) or for symptoms you currently experience (PRESENT)

- | PAST | PRESENT | | PAST | PRESENT | |
|--------------------------|--------------------------|------------------------------|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | General fatigue | <input type="checkbox"/> | <input type="checkbox"/> | Skin rash, dermatitis, eczema |
| <input type="checkbox"/> | <input type="checkbox"/> | Headache | <input type="checkbox"/> | <input type="checkbox"/> | Chronic sinus problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Tinnitus, noises in the ear | <input type="checkbox"/> | <input type="checkbox"/> | Excessive thirst |
| <input type="checkbox"/> | <input type="checkbox"/> | Fainting | <input type="checkbox"/> | <input type="checkbox"/> | Chronic cough |
| <input type="checkbox"/> | <input type="checkbox"/> | Vision disturbances | <input type="checkbox"/> | <input type="checkbox"/> | Chest pain |
| <input type="checkbox"/> | <input type="checkbox"/> | Convulsions | <input type="checkbox"/> | <input type="checkbox"/> | Rapid heart beat |
| <input type="checkbox"/> | <input type="checkbox"/> | Dizziness, lightheadedness | <input type="checkbox"/> | <input type="checkbox"/> | Difficulty swallowing |
| <input type="checkbox"/> | <input type="checkbox"/> | Muscular incoordination | <input type="checkbox"/> | <input type="checkbox"/> | Heartburn and/ or indigestion |
| <input type="checkbox"/> | <input type="checkbox"/> | Generalized muscle pain | <input type="checkbox"/> | <input type="checkbox"/> | Loss of appetite |
| <input type="checkbox"/> | <input type="checkbox"/> | TMJ (jaw) pain | <input type="checkbox"/> | <input type="checkbox"/> | Nausea |
| <input type="checkbox"/> | <input type="checkbox"/> | Neck pain | <input type="checkbox"/> | <input type="checkbox"/> | Abdominal pain |
| <input type="checkbox"/> | <input type="checkbox"/> | Back pain | <input type="checkbox"/> | <input type="checkbox"/> | Loss of bladder or bowel control |
| <input type="checkbox"/> | <input type="checkbox"/> | Joint swelling | <input type="checkbox"/> | <input type="checkbox"/> | Painful urination |
| <input type="checkbox"/> | <input type="checkbox"/> | Joint stiffness | <input type="checkbox"/> | <input type="checkbox"/> | Frequent urination |
| <input type="checkbox"/> | <input type="checkbox"/> | Shoulder pain | <input type="checkbox"/> | <input type="checkbox"/> | Difficult urination or changes in stream |
| <input type="checkbox"/> | <input type="checkbox"/> | Arm pain | <input type="checkbox"/> | <input type="checkbox"/> | Constipation |
| <input type="checkbox"/> | <input type="checkbox"/> | Elbow pain | <input type="checkbox"/> | <input type="checkbox"/> | Irregular bowel habits |
| <input type="checkbox"/> | <input type="checkbox"/> | Wrist, Hand pain | <input type="checkbox"/> | <input type="checkbox"/> | Irregular menstrual flow |
| <input type="checkbox"/> | <input type="checkbox"/> | Hip pain | <input type="checkbox"/> | <input type="checkbox"/> | Excessive menstrual flow |
| <input type="checkbox"/> | <input type="checkbox"/> | Leg pain | <input type="checkbox"/> | <input type="checkbox"/> | Breast tenderness and/ or lumps |
| <input type="checkbox"/> | <input type="checkbox"/> | Knee pain | <input type="checkbox"/> | <input type="checkbox"/> | Vaginal discharge |
| <input type="checkbox"/> | <input type="checkbox"/> | Ankle, foot pain | <input type="checkbox"/> | <input type="checkbox"/> | PMS |
| <input type="checkbox"/> | <input type="checkbox"/> | Enlarged lymph nodes, glands | <input type="checkbox"/> | <input type="checkbox"/> | ED |

Signature _____

Date _____