Bentin Chiropractic
Wellness Center
(561) 736-WELL (9355)
(561) 736-6661 (Fax)

Personal Injury Questionnaire

Patient Information

First Name_____ M.I._____ Last_____
Home Address_____ Apt # _____
City_____ State_____ Zip_____
Home Phone_____ Cell Phone_____
Work Phone_____ E-mail Address _____
Birthdate: _____/_____/_____ Gender: ☐ M ☐ F Age:_____
Social Status: ☐Single ☐Married ☐Divorced ☐Widowed ☐Separated
Social Security Number _____
How did you hear about us? ☐Coupon/Gift Cert. ☐Internet ☐Banner ☐Referred By:_____
Employer Name_____ Occupation_____
Employer Address_____

Who to Contact in Case of Emergency:

Name_____ Relation to Patient_____
Home Phone _____ Work phone_____ Ext_____

Insurance information

- Driver of Vehicle in which you were injured:_____
  Insurance Company:_____ Policy#_____
  Address:_____
- Does their policy include Personal Injury Protection (PIP): ☐Yes ☐No
- Accident Claim #:_____ Insurance Adjuster Name:_____
  Adjuster Phone Number:_____
  Address to send billing information:_____
- Driver of Other vehicle (if any):_____ Policy#_____
  Insurance Company:_____ Address:_____
- Your Insurance Company (if you were in another persons vehicle):_____
  Policy #:_____ Does YOUR policy include Personal Injury Protection (PIP): ☐Yes ☐No
- Have you retained an Attorney: ☐Yes ☐No If yes, name of Attorney:_____
  Address:_____

Accident Information

- Please explain ***IN DETAIL*** how your accident happened: _____
- Time and Date of Accident:_____
- Where did the accident occur? (Intersection or Highway, etc.)_____
- Were the police notified of the accident? ☐Yes ☐No
- You were heading: ☐North ☐South ☐West ☐East
- Other Vehicle was headed: ☐North ☐South ☐West ☐East
- Were you struck from : ☐Behind ☐Front ☐Drivers Side ☐ Passenger Side
- What were the circumstances (were you stopped, moving, turning, etc.)?:_____
- Was any one else in your car at the time of the accident? ☐Yes ☐No Were they injured? ☐Yes ☐No
- You were the: ☐Driver ☐Passenger ☐Front Seat ☐Back Seat ☐Using Seat Belts
- Head rest in proper position (top of head rest at center of back of head)? ☐Yes ☐No

- Did you hit your head or knees: ☐Yes ☐No Seat came loose? ☐Yes ☐No

Patient Name_____ **Date**_____

- What were your immediate symptoms: ☐Dizzy ☐Unconscious, how long:_____
  ☐ Pain, where:_____ ☐Other:_____
- Primary Complaint Now:_____
- Pains are: ☐ Sharp ☐Dull ☐ Throbbing ☐ Aching ☐ Numbness ☐ Shooting
  ☐ Burning ☐Tingling ☐Spasm ☐ Stiffness ☐ Swelling ☐ Other_____
- Is this condition getting progressively worse? ☐ Yes ☐No ☐ Unknown
- Is the pain: ☐Occasional (0-25%) ☐Intermittent (25-50%) ☐Frequent (50-75%) ☐Constant (75-100%)
- Does the pain radiate? ☐Yes ☐ No, if yes, Where does it radiate?_____
- Activities or movements that are difficult to perform:
  ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐Lying Down ☐ Other_____
- What treatment have you already received for this condition? ☐ Medications ☐ Physical Therapy
  ☐ Surgery ☐ Chiropractic ☐ None ☐Other_____
- Activities or movements that improve the condition:_____
- Second Complaint_____ When did it start? _____
- Did you go to the Doctor/Hospital after the accident? ☐Yes ☐No If yes, what treatment was given:_____
- Was any other Doctor consulted after your accident? ☐Yes ☐ No
  If yes, Doctor's name:_____ ☐D.C. ☐M.D. ☐D.O. ☐P.A.
- How many times were you seen?_____Diagnosis:_____
- Have you had any complaints in involved area before? ☐Yes ☐No
  If yes, explain:_____
- Has anyone recommended surgery? ☐Yes ☐No
- How do you feel in a.m.? ☐Better ☐Worse ☐ No difference
- How do you feel in p.m.? ☐Better ☐Worse ☐ No difference
- Is condition getting worse? ☐Yes ☐No ☐ Constant ☐Comes and goes
- Have you been unable to work since the accident? ☐Yes ☐No
  Dates unable to work:_____
- Are you partially disabled? ☐Yes ☐No if yes,
  explain:_____
- What can you **NOT** do now that you could do before?:_____
- Before this injury, were you able to work on an equal basis with others your age? ☐Yes ☐No
- Medications you are taking now due to the Accident: ☐Pain Killers ☐Anti-Inflammatory ☐Muscle Relaxers
  ☐Others:_____

Check symptoms you have noticed *SINCE THE ACCIDENT*:

☐ Headache	☐ Neck Pain	☐ Neck Stiffness	☐ Insomnia	☐ Tension
☐ Irritability	☐ Loss of Taste	☐ Loss of Smell	☐ Loss of Memory	☐ Diarrhea
☐ Neuritis	☐ Anxiety	☐ Fainting	☐ Chest pain	☐ Dizziness
☐ Constipation	☐ Depression	☐ Eye strain	☐ Nausea, vomiting	☐ Face flushed
☐ Palpitation	☐ Tremors	☐ Pallor	☐ Sinus trouble	☐ Mental Dullness
☐ Extreme Nervousness	☐ Extreme Fatigue	☐ Pain Behind Eyes	☐ Double Vision	☐ Digestive Disorder
☐ Equilibrium Disorder	☐ Head seems too heavy	☐ Shortness of breath	☐ Excessive perspiration	☐ Upper back- pain, stiff
☐ Mid-back- pain, stiff	☐ Feet cold; Hands cold	☐ Restricted Neck Motion	☐ Buzzing/Ringing Ears	☐ Eyes Sensitive to light
☐ Head/Shoulders Feel tired/heavy	☐ Pins and Needles in arms/legs	☐ Numbness in fingers/arms/legs	☐ Difficulty in prolonged riding in car	☐ Difficulty in excessive lifting
☐ Neck/Low Back pain/stiffness upon rising	☐ Pain radiating into right/left/both arms/leg	☐ Difficulty in excessive standing/walking/bending	☐ Difficulty in excessive turning/twisting	☐ Difficulty in rising to walk after sitting

Patient Name_____ **Date**_____

Health Information

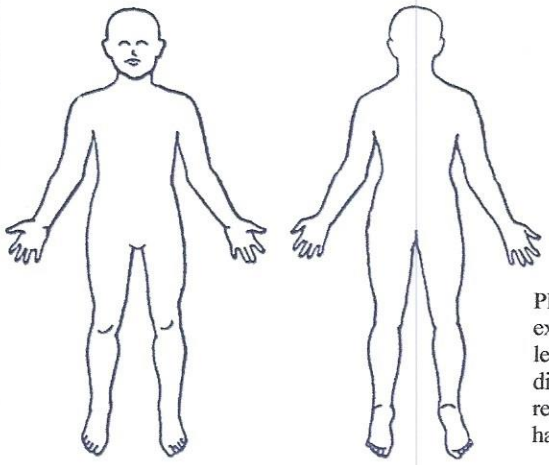
- Date of last Physical Examination:_____ Have you had previous Chiropractic Care?: ☐Yes ☐No
  Doctor's Name:_____ When?_____
  Why?_____ Were x-rays taken? ☐Yes ☐No
- Are you Pregnant? ☐YES ☐NO Nursing? ☐YES ☐NO
- Who is you current medical doctor?_____
- Please list *ALL* Surgeries you've had:_____
- Allergies:_____
- Please list *ALL* Medications you are taking?_____
- Are you Pregnant? ☐YES ☐NO Nursing? ☐YES ☐NO Taking Birth Control? ☐YES ☐NO
- Do you Smoke? ☐ YES ☐ NO if Yes, how much? _____ packs/day
- Do you Drink Alcohol? ☐ YES ☐NO How Much? _____glass/ (circle one) Day Week Month Year
- How much do you exercise? _____minutes/ (circle one) Day Week Month Year

Mark Any Condition you have either had in the Past or Currently Have:

☐AIDS/HIV	☐Depression	☐Liver Disease	☐Psychiatric Care
☐Alcoholism	☐Diabetes	☐Measles	☐Rheumatoid Arthritis
☐Allergy Shots	☐Emphysema	☐Migraine Headaches	☐Rheumatic Fever
☐Anemia	☐Epilepsy	☐Miscarriage	☐Sinus Problems
☐Anorexia	☐Fractures	☐Mononucleosis	☐Stroke
☐Appendicitis	☐Glaucoma	☐Multiple Sclerosis	☐Suicide Attempt
☐Arthritis	☐Goiter	☐Mumps	☐Thyroid Problems
☐Bleeding Disorder	☐Gonorrhea	☐Osteoporosis	☐Tonsillitis
☐Breast Lump	☐Gout	☐Pacemaker	☐Tuberculosis
☐Bronchitis	☐Heart Disease	☐Parkinson's Disease	☐Tumors, Growths
☐Bulimia	☐Hepatitis	☐Pinched Nerve	☐Typhoid Fever
☐Cancer	☐Hernia	☐Pneumonia	☐Ulcers
☐Cataracts	☐Herniated Disc	☐Polio	☐Vaginal Infections
☐Chemical Dependency	☐Herpes	☐Psychiatric Problems	☐Venereal Disease
☐Chicken Pox	☐High Cholesterol	☐Prostate Problems	☐Other_____

Pain Diagram

Area of Most Pain
Better Pain at Present: Worse 0—1—2—3—4—5—6—7—8—9—10
Pain at its Worse: 0—1—2—3—4—5—6—7—8—9—10
Pain at its Best: 0—1—2—3—4—5—6—7—8—9—10
Area 2nd Most Pain
Better Pain at Present: Worse 0—1—2—3—4—5—6—7—8—9—10
Pain at its Worse: 0—1—2—3—4—5—6—7—8—9—10
Pain at its Best: 0—1—2—3—4—5—6—7—8—9—10



KEY	
Stabbing	xxx
Pins & Needles	ooo
Numbness	= =
Aching	+++
Burning	////

Please indicate where you are experiencing pain by drawing the letter abbreviations on the diagrams that most accurately reflect the type of discomfort you have been experiencing.

BENTIN CHIROPRACTIC

7545 W. Boynton Beach Blvd., Suite. 102
Boynton Beach, FL 33437
Telephone: (561) 736-9355

Authorization

PATIENT NAME _____

I certify that I'm the patient or legal guardian listed above. I have read/understand the included information and certify it to be true and accurate to the best of my knowledge. I consent to the collection and use of the above information to this office of chiropractic.

I authorize this office and its staff to examine and treat my condition as the doctors see fit. I hereby authorize the doctor to release all information necessary to any insurance company, attorney, or adjuster for the purpose of claim reimbursement of charges incurred by me. I grant the use of my signed statement of authorization with my signature for required insurance submissions. I understand and agree that all services rendered to me will be charged to me, and I'm responsible for timely payment of such services. I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand that fees for professional services will become immediately due upon suspension or termination of my care or treatment.

* ☐ **I agree with this statement of authorization**

SIGNATURE _____

DATE: _____

BENTIN CHIROPRACTIC

7545 W. Boynton Beach Blvd., Suite 102
Boynton Beach, FL 33437
Telephone: (561) 736-9355

RELEASE OF MEDICAL RECORDS:

I am requesting that my medical records be released to:

Bentin Chiropractic Wellness Center
7545 Boynton Beach Blvd. Suite 102
Boynton Beach, Florida 33447
Phone: 561-736-9355 Fax: 561-736-6661

Patient Signature:_____

Date: _____

BENTIN CHIROPRACTIC

7545 W. Boynton Beach Blvd., Suite 102
Boynton Beach, FL 33437
Telephone: (561) 736-9355

FINANCIAL POLICY

Insurance is a contract between you and your insurance company. As a courtesy to you, we will verify your chiropractic benefits and file claims to your insurance company. Verification of your insurance is not a guarantee of benefits or payment. Your insurance company will make the final determination of your eligibility and subsequent payments

Payments: A payment is due to your account on the date of service unless other written arrangements have been approved. If there is a balance on your monthly statement, payment is due within 30 days unless other written arrangements have been approved. If no payment is made after 60 days or more, we will take necessary steps to collect this debt. If we refer your account to a collection agency, there will be an additional collection agency fee added to your balance.

Returned Checks: There will be a $12.00 fee assessed for all returned checks.

I have read and understand the financial policy and agree to all terms and conditions stated herein. I agree to make payments on my account on each date of service unless other arrangements have been made.

Patient's Name:_____

Patient Signature:_____

Responsible Party (if not the patient): _____

Date: _____

AUTHORIZATION TO PAY PHYSICIAN

I hereby authorize the _____ Insurance Company to pay by check and made out and mailed directly to:

BENTIN CHIROPRACTIC WELLNESS CENTER
7545 W. Boynton Beach Blvd. Suite 102
Boynton Beach, Fl. 33437

the medical and surgical expense benefits allowable, and otherwise payable to me under my current insurance policy, as payment toward the total charges for Professional Services rendered. This payment will not exceed my indebtedness to the above mentioned assignee, and I agree to pay, in a current manner, any balance of said Professional Service charge over and above this insurance payment.

If my current policy prohibits direct payment to doctor, then I hereby authorize you to make the check to me and mail it as follows:

c/o

BENTIN CHIROPRACTIC WELLNESS CENTER
7545 W. Boynton Beach Blvd. Suite 102
Boynton Beach, Fl. 33437

THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.

A photocopy of this Assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

Date _____

_____
Signature of Policyholder

_____
Witness

_____
Signature of Claimant

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.**

Spinal Manipulation, HOt Packs, Ultrasound, Electrical Mus. Stim Trigger point Therapy, Cold Laser, Manual Therapy, Therapeutic Exercises,Range of Motion, Muscle Testing

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 (15) and (16), 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**)*:

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.