Robin Chiropractic Health Center

PERSONAL INFORMATION

Date: _____/_____/_____

Name:_____ Social Security #:_____

Address:_____ Age:_____ Sex: ☐ M ☐ F

City:_____ Date of Birth :_____/_____/_____

State:____ Zip:_____ Phone:_____ Driver's License #:_____

Occupation:_____ Employer:_____

Who referred you to our office?_____

ACCIDENT INFORMATION

1. What type of accident were you involved in? ☐ Auto Accident ☐ Fall ☐ Other:_____
2. Date of accident: _____/_____/_____ 3. Time of accident:_____ AM PM
4. Location of accident:_____
5. Please explain how your accident happened:_____

_____

6. Were you injured in this accident? ☐ Yes ☐ No If so, please list your complaints:_____

_____

7. Were you knocked unconscious in this accident? ☐ Yes ☐ No
8. Were you hospitalized as a result of this accident? ☐ Yes ☐ No
9. Have you received care/treatment for your injuries? If so, please explain:_____

_____

10. Prior to your accident, did you have any problems/illnesses relating to your injuries? ☐ Yes ☐ No

If so, please explain:_____

_____

QUESTIONS 11 - 15 ARE FOR AUTO ACCIDENT VICTIMS ONLY.

11. Was the accident reported to police? ☐ Yes ☐ No
12. What type of vehicle were you in (truck, car, van etc)?_____
13. Where in the vehicle were you sitting?_____
14. Were you wearing a seatbelt? ☐ Yes ☐ No
15. Have you ever been in an auto accident before? ☐ No ☐ Yes (please complete the following)

DATE OF ACCIDENT	**WERE YOU INJURED (If so, please list your injuries)?**
_____/_____/_____	☐ No ☐ Yes:_____
_____/_____/_____	☐ No ☐ Yes:_____
_____/_____/_____	☐ No ☐ Yes:_____

GENERAL HEALTH INFORMATION

16. Who is you family physician?_____

17. Are you currently taking any medications? If so, please list them here:_____

_____

18. **Women only:** Are you currently pregnant? ☐ Unsure at this time ☐ Yes, due date:_____ ☐ No

19. Do you have a pacemaker? ☐ No ☐ Yes

20. Have you ever been hospitalized? If so, please explain:_____

_____

21. Have you ever had any fractures, broken bones or other injuries? If so, please explain:_____

_____

22. Have you ever had surgery? If so, please explain:_____

_____

23. Do you have any other health problems? If so, please explain:_____

_____

ATTORNEY INFORMATION:

24. Do you have an attorney representing you for this accident? ☐ No ☐ Yes

Attorney's Name:_____City:_____

HEALTH INSURANCE INFORMATION:

25. Health insurance coverage: ☐ Medicaid ☐ Medicare ☐ Group Insurance ☐ Other:_____

Policy #:_____

AUTO INSURANCE INFORMATION:

26. Name of your auto insurance company/agent:_____ City:_____

I hereby certify that all information provided is true, accurate and complete to the best of my knowledge. I hereby authorize Dr. Craig A. Robin to examine, x-ray, and treat me . I understand that all services rendered to me are charged directly to me and that I am personally responsible for payment. I hereby authorize the release of information regarding my evaluation, treatment, diagnosis, bills and any other information regarding myself necessary to secure payment of my charges, to my attorney, health insurance company, auto insurance company or any other entity or insurance adjuster. I understand that if I suspend my care at Robin Chiropractic Health Center, all charges become immediately due and payable.

_____

Signature of Patient/Legal Guardian Date