TQ CHIROPRACTIC
CONFIDENTIAL PATIENT INFORMATION

(PLEASE PRINT)

PATIENT:

Last Name: _____ First Name: _____ Middle: _____

Gender: M F Date of Birth: _____/_____/_____ Age: _____ SSN#: _____

Martial Status: □ Married / □ Single / □ Divorced How many children? _____

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone #: _____ Work Phone #: _____ Cell phone #: _____

Employer Name: _____ Occupation: _____

Employer Address: _____

City: _____ State: _____ Zip: _____

EMAIL: _____ REFERRED BY: _____

PRIMARY CARE PHYSICIAN: _____ PHONE: _____

SPOUSE or GUARDIAN:

Last Name: _____ First Name: _____ Middle: _____

Home Phone #: _____ Work Phone #: _____ Cell phone #: _____

Employer Name: _____

Date of Birth: _____/_____/_____ SSN#: _____

EMERGENCY (Name and address of nearest relative or friend **not living with you**)

Last Name: _____ First Name: _____ Middle: _____

Home Phone #: _____ Work Phone #: _____ Cell phone #: _____

Relation to Patient: _____

PAYMENT METHOD: □ **Cash** □ **Check** □ **Visa** □ **Mastercard**

INSURANCE:

Insurance Company: _____

Insured's Name: _____ ID/Policy #: _____

Insured's Date of Birth: _____ Insured's Gender: M F

Patient Relationship to Insured: □ **Self** □ **Spouse** □ **Child** □ **Other:**

Workers Compensation _____

Insured's Name: _____ ID/Policy #: _____

Is there another health Benefit Plan? □ YES □ NO (If yes, please indicate below)

Insurance Company: _____

Insured's Name: _____ ID/Policy #: _____

Insured's Date of Birth: _____ Insured's Gender: M F

Patient Relationship to Insured: □ Self □ Spouse □ Child □ Other:

Patient's Race: □ White □ Black/African American □ Hispanic □ American Indian □ Asian

□ Chinese □ Filipino □ Japanese □ Korean □ Vietnamese □ Hawaiian or other pacific Islander

□ Samoan □ Other □ Patient Refused to specify

Patient's Ethnicity: □ Hispanic or Latino □ Not Hispanic or Latino □ Patient Refused to specify

Patient's Preferred Language: □ English □ Spanish □ Vietnamese □ Chinese □ Other: _____

RESPONSIBLE PARTY: Complete this section if you are not the patient but are responsible for the bill

Responsible Party: _____ Relationship to Patient: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone #: _____ Work Phone #: _____ Cell phone #: _____

Employer Name: _____ Occupation: _____

We are committed to providing you with the best possible care. Coinsurance (co-payment) is due at the time services are rendered. Returned checks and balances older than 60 days may be subject to additional collection fees and interest charge of 1.5 percent per month. All returned checks will be charged an additional $25 fee. Not all services are a covered benefit in all contracts. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are the patient's responsibility. If your insurance does not pay within 60 days of the date of service you will be responsible for paying this bill.

ASSIGNMENT: I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. Further more, I understand that **TQ Chiropractic** will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to **TQ Chiropractic** will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

I have read all the information above. I hereby assign all insurance benefits to TQ Chiropractic. I understand and agree that I am financially responsible for all charges incurred to my account whether my insurance pays or not. I agree that in the event of non-payment, within 60 days I will be responsible for the bill payment. I will bear the cost of collection or court costs and attorney fees. I certify that all the information is true and correct to the best of my knowledge. I will notify this office of any changes in my health or billing information. A photocopy of this authorization shall be as valid as the original.

SIGNATURE: (Patient, Parent, Legal Guardian or Responsible Party)

Patient / Guardian Signature _____ Date: _____

TQ CHIROPRACTIC - AUTO ACCIDENT

Patient Name _____ **Date**_____

Date of accident: _____ Time of accident: _____ ☐ a.m. ☐ p.m.

Were you the: ☐ Driver ☐ Front Passenger ☐ Rear passenger

Make and model of the vehicle you were occupying? _____

If a traffic violation was issued, to whom was it issued? _____

Number of people in accident vehicle? _____.

Did the police come to the accident site? ☐ Yes ☐ No

Was a police report filed? ☐ Yes ☐ No

Were there any witnesses? ☐ Yes ☐ No

Were you wearing a seat belt? ☐ Yes ☐ No

Was this vehicle equipped with airbags? ☐ Yes ☐ No
If yes, did it/they inflate?

In relation to the base of your skull, where was the headrest? ☐ Above ☐ Below ☐ At base of skull

What did your vehicle impact? ☐ Another vehicle ☐ other
If other, explain? _____

Did any part of your body strike anything in the vehicle? ☐ Yes ☐ No
If yes, please describe: _____

Make and model of the other vehicle(s) involved? _____

Name of the location/street on which you were traveling? _____

In which direction were you headed? ☐ N ☐ S ☐ E ☐ W

What was the approximate speed of your vehicle? _____.

Did the impact to your vehicle come from the: ☐ Front ☐ Rear ☐ Right Side ☐ Left Side ☐ Othe

During impact, were you facing: ☐ Right ☐ Left ☐ Forward

Were you: ☐ aware or ☐ surprised by the impact?

If accident vehicle made impact with another vehicle …….
Direction other vehicle was headed? ☐ N ☐ S ☐ E ☐ W

Approximate Speed of the other vehicle ? _____.

In your words, please describe the accident: _____

_____

_____

_____

_____

Patient Name _____ **Date**_____

After Injury

Did the accident render you unconscious? ☐ Yes ☐ No

If yes, for how long? _____

Please describe how you felt immediately after the accident: _____

Have you gone to a hospital or seen any other Doctor? ☐ Yes ☐ No

When did you go? ☐ Just after accident ☐ The next day ☐ 2 days plus

How did you get there? ☐ Ambulance ☐ Private transportation

Name of hospital and/or attending doctor: _____

Was he/she a: ☐ D.C. ☐ M.D. ☐ D.O. ☐ D.D.S.

Describe any treatment you received: _____

Were X-Rays taken? ☐ Yes ☐ No

Was medication prescribed? ☐ Yes ☐ No

Have you been able to work since this injury? ☐ Yes ☐ No

Indicate the symptoms that are a result of this accident:

☐ Dizziness	☐ Shortness of breath	☐ Chest pain	☐ Fatigue
☐ Memory loss	☐ Arms / shoulder pain	☐ Stomach upset	☐ Tension
☐ Headache(s)	☐ Numb hands /fingers	☐ Back stiffness	☐ Neck pain
☐ Blurred vision	☐ Difficulty sleeping	☐ Jaw problems	☐ Neck stiff
☐ Buzzing in ear	☐ Lower back pain	☐ Ears ringing	☐ Nausea
☐ Irritability	☐ Numb feet/toes	☐ Leg pain	☐ Back pain

☐ Other _____

_____

Is your condition getting worse? ☐ Yes ☐ No ☐ Constant ☐ Comes and goes

Have you retained an attorney? ☐ Yes ☐ No

If yes, whom? _____

His / Her phone #: _____

Patient Name _____ **Date**_____

Indicate your degree of comfort while performing the following activities:

	Comfortable	Uncomfortable	Painful
Lying on back ……	☐	☐	☐
Lying on side ……	☐	☐	☐
Lying on stomach ……	☐	☐	☐
Sitting ……	☐	☐	☐
Standing ……	☐	☐	☐
Stretching ……	☐	☐	☐
Walking ……	☐	☐	☐
Running ……	☐	☐	☐
Sports ……	☐	☐	☐
Working ……	☐	☐	☐
Lifting ……	☐	☐	☐
Bending ……	☐	☐	☐
Kneeling ……	☐	☐	☐
Pulling ……	☐	☐	☐
Reaching ……	☐	☐	☐

Recovery

How many hours are in your normal workday? _____.

Please indicate on your daily job duties and any activities which you are occasionally asked to perform.

☐ Standing	☐ Driving	☐ Operating equipment
☐ Sitting	☐ Twisting	☐ Work with arms above head
☐ Walking	☐ Crawling	☐ Typing
☐ Lifting	☐ Bending	☐ Stooping

☐ Other _____

What positions can you work in with minimum physical effort and for how long?

_____ □ N/A

Prior to the injury were you capable of working on an equal basis with others your age? ☐ Yes ☐ No ☐ N/A

Do you work with others who can help you with any heavy lifting ☐ Yes ☐ No ☐ N/A

While in recovery, is there any light duty work you could request? ☐ Yes ☐ No ☐ N/A