DuPage Healthcare, Ltd.
LIVING WELL STARTS HERE

PERSONAL INJURY - NEW PATIENT INTAKE

Welcome to our office!

On behalf of the staff and myself, welcome to our office.

It is my sincere hope that our office will exceed your healthcare experience while addressing your most important asset-**your health.**

Please complete the attached paperwork to ensure a smooth transition into our office.

In addition to your injury information, we will also require you to bring your health insurance cards(s) and a valid photo ID for our records.

Thanks again for choosing DuPage Healthcare, we look forward to serving you.

Dr. Sally Pepping

How did you hear about DuPage Healthcare?

☐ Friend or family member ☐ Facebook ☐ Google
☐ I am a current patient ☐ I am a previous patient

Who may we thank for trusting us with your care? _____

Personal Information

First Name: _____ **Last Name:** _____

Address: _____ **Date of Birth:** _____

City: _____ **Cell Phone:** _____

State: _____ **Zip:** _____ **Work Phone:** _____

Email: _____

Marital Status

☐ Married ☐ Single ☐ Engaged
☐ Divorced ☐ Widowed ☐ Significant Other

Spouse/Significant

First Name **Last Name** **Cell**

_____ _____ _____

Car Accident

Please Note:
Our office only accepts Med Pay, which is through the auto policy of the care you were injured in. If you were in your car then your claim will be through your auto insurance policy. If you were injured in a car that was not yours then your claim will be through the auto insurance policy of the that car's owner.

What is the date of your injury?

_____

Which of these accurately describes your situation?

☐ I am the owner of the car ☐ I am not the owner – *Fill out information below*

Car's owner's name: _____

Car owner's phone number: _____

Car owner's relationship to you _____

Was anyone else in the car with you?

☐ Yes ☐ No

Were they injured?

☐ Yes ☐ No

Please list the names of the other people who were in the car with you:

Auto Insurance Policy Information

Name of the Insurance Company that insures the (CAR YOU WERE IN) _____

Claim # (from the insurance company of the (CAR YOU WERE IN) _____

Policy # (CAR YOU WERE IN) # _____

Adjustor's Name: _____ **Address:** _____

Phone # and Ext: _____ **City:** _____

Adjustors Email: _____ **State:** _____ **Zip:** _____

Attorney Information

It is not always necessary to retain an attorney. Please talk to Dr. Pepping before making this decision. If you do retain an attorney, it is your responsibility to notify us immediately.

Did you retain an Attorney? ☐ **Yes** ☐ **No** ☐ **Considering it**

Firm's Name: _____ **Address:** _____

Attorney's Name: _____ **City:** _____

Phone # and Ext. _____ **State:** _____ **Zip:** _____

Injury Details

Please explain in detail how your injury happened.

Describe how you felt immediately after the accident.

Check the symptoms you had and currently have since the accident

- ☐ Headaches
- ☐ Neck Pain
- ☐ Pain shooting into the leg(s)
- ☐ Difficulty sleeping
- ☐ Dizziness
- ☐ Lower Back Pain
- ☐ Numbness in your feet
- ☐ Confusion
- ☐ Pain shooting into the arm(s)
- ☐ Numbness in your hands

Please list additional symptoms not listed above

_____

Were you taken to the hospital?

☐ Yes-and released that day ☐ Yes-and was admitted ☐ No

What tests, treatments, or recommendations were given?

_____

Have you consulted other Doctors?

☐ Yes ☐ No

Who have you consulted?

_____

Quality of Life Survey

Please take your time answering this section as honest as possible

How have you taken care of your health in the past?

- [ ] Routine medical
- [ ] Exercise
- [ ] None of the above
- [ ] Medications
- [ ] Nutrition/Diet
- [ ] Emergency room
- [ ] Holistic Care

How have others been affected by your condition?

- [ ] They tell me to do something
- [ ] Haven't notices any problems
- [ ] They are tired of me complaining
- [ ] None of the above

How did these methods work for you?

- [ ] Bad Results
- [ ] Results Did Not Last
- [ ] Still Trying
- [ ] Some Results
- [ ] Symptoms Stayed the Same
- [ ] I'm Confused/Frustrated
- [ ] Great Results
- [ ] No Changes
- [ ] None of the above

What areas of your life has this problem affected?

- [ ] My job
- [ ] My self-esteem
- [ ] My recreational activities
- [ ] Playing with my grandkids
- [ ] My marriage/relationship
- [ ] My independence
- [ ] My social life
- [ ] Ability to exercise
- [ ] My sleep
- [ ] My household work
- [ ] Playing with my kids
- [ ] None of the above

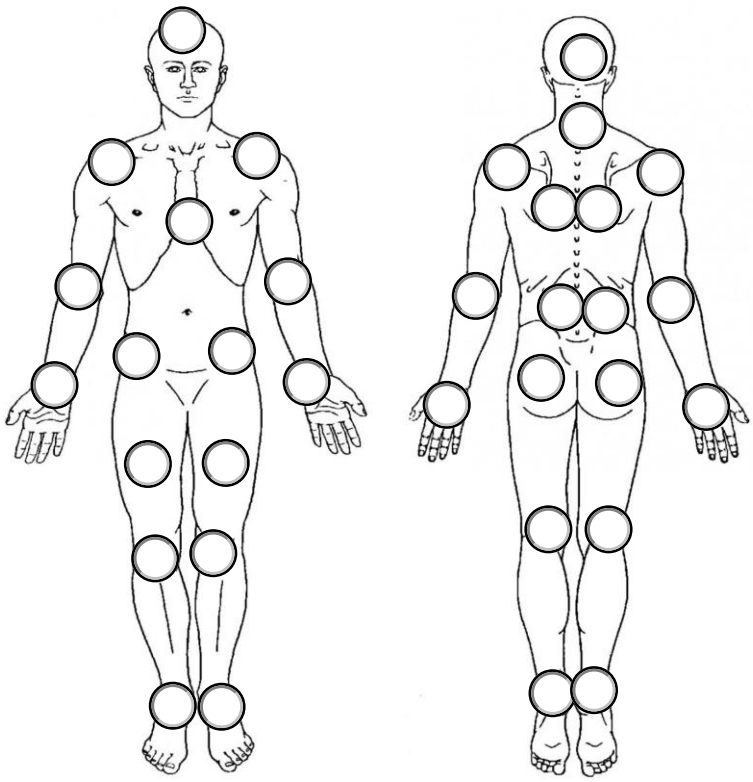
If left untreated and your condition worsens, where do you see yourself in 1-2 year?

- [ ] Surgery
- [ ] Depression
- [ ] Disability
- [ ] More Medication
- [ ] Loss of work
- [ ] None of the above
- [ ] Hospitalization
- [ ] Loss of independence

If tomorrow your condition disappeared, how would your life be better?

What do you desire most by working with our team?

Click on an area below, where you feel pain, numbness, or tingling.
Or write your area in the space below.



Health History

Please check each of the diseases or conditions that you have had now or in the past. While they may seem unrelated to the purpose of the appointment, they can affect the overall diagnosis, care plan, and the possibility of being accepted for care.

- ☐ Severe/Frequent Headaches
- ☐ Cancer
- ☐ Pain Between the Shoulders
- ☐ Lower Back Problems
- ☐ Heart Attack/Stroke
- ☐ Congenital Heart Detect
- ☐ Psychiatric Problems
- ☐ Asthma
- ☐ Venereal Disease
- ☐ Tuberculosis
- ☐ Anemia
- ☐ Sinus Problems
- ☐ Loss of Sleep
- ☐ Frequent Neck Pain
- ☐ Digestive Problems
- ☐ Thyroid Problems
- ☐ Heart Surgery/Pacemaker
- ☐ Difficulty Breathing
- ☐ Arthritis
- ☐ HIV/AIDS
- ☐ Shingles
- ☐ Pacemaker
- ☐ Dizziness
- ☐ Hepatitis
- ☐ Numbness or Pain in Arms/Legs/Hands
- ☐ Ulcers/Colitis
- ☐ Kidney Problems
- ☐ High/Low Blood Pressure
- ☐ Rheumatic Fever
- ☐ Alcohol/Drug Abuse
- ☐ Diabetes
- ☐ Chemotherapy

Authorization for Care

I hereby authorize the Doctor to work with my condition through the use of adjustments to my spine, as he or she deems appropriate.

I clearly understand and agree that all the services rendered to me are charged directly to me and that I am personally responsible for all payment. I agree that I am responsible for all the bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I also understand that if I suspend or terminate my care, any fees for professional services rendered to me will become immediately due and payable. I hereby authorize assignment of my insurance rights and benefits (if applicable) directly to the provider of services rendered.

Patient's Signature: _____ **Date:** _____

Are you a guardian or under the age of 18?

☐ Yes ☐ no

Guardian Information

Guardian's First Name: _____ **Cell Phone:** _____

Guardian's Last Name: _____ **Work Phone:** _____

Relationship to the patient: _____

Guardian or Spouse's Signature: _____ **Date:** _____

My Health Insurance

I understand that as long as I provide accurate information pertaining to my injury and abide by all of DuPage Healthcare, Ltd.'s policies that they will send all claims to the appropriate agencies. I also understand that it is my responsibility to provide accurate health insurance information at the time care starts or at any time insurance is obtained during treatment.

I understand that my health insurance will not be billed for my injuries unless claims are denied or not fully paid.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I understand that the Doctor's Office will provide any necessary reports and forms to assist me in collecting from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account upon receipt.

I have read and agree with the above statement.

Patient's Signature: _____ Date: _____

YOUR HEALTH INSURANCE

☐ I am an existing patient, and you have my current Insurance
☐ I don't have health insurance

Insurance Company: _____

Policy # _____

Phone Number: _____

Address: _____

Group # _____

Are you the carrier of this health insurance policy?

☐ Yes-*Skip About the Insured person*
☐ No

About the Insured Person

First Name: _____

Last Name: _____

Relationship to the patient: _____

Date of birth: _____

Social Security: _____

Cell: _____

Agreement

My signature below signifies my agreement for payment in full on a cash basis if I have not provided all the necessary documents and information by the time of the second visit.

I have read and agree with the above statement.

Patient's Signature: _____ Date: _____

Printed Name: _____

DuPage Healthcare,Ltd.
LIVING WELL STARTS HERE

45 S. Park Blvd. Ste 155
Glen Ellyn, IL 60137
630-238-8200
frontdesk@dupagehealthcareltd.com

MEDICAL LIEN

Insurance Adjuster

Please print:

Claim #: _____

Auto Insurance Name: _____

Adjuster's Name: _____

Address: _____

City/State/Zip: _____

Phone #: _____

Patient's Name: _____

Address: _____

City/State/Zip: _____

Phone #: _____

I do hereby authorize the above medical provider to furnish you, my adjuster, with a full report of their examination, diagnosis, treatment, prognosis, etc. of myself in regard to the incident in which I was involved.

I hereby authorize and direct you, my adjuster, to pay directly to said provider such sums as may be due and owing for medical services rendered to me both by reason of this incident and by reason of another settlement, judgment or verdict as may be necessary to adequately protect said provider.

I hereby further give a lien on my case to said provider against any and all proceeds of any settlement, judgment or verdict which may be paid to you, my adjuster, or myself as the result of the injuries for which I have been treated or injuries in connection therewith.

I fully understand that I am directly and fully responsible to said providers for all the medical bills submitted by DuPage Healthcare, Ltd for services rendered to me and, that this agreement is made solely for said provider's additional protection and in consideration of their awaitingpayment. I further understand that such payment is not contingent on any settlement, judgment, or verdict by which I may eventually recoversaid fee.

I agree that if I change adjusters, that this agreement will remain in force and effect and that I will notify any subsequent adjuster of this lien and notify you the name, address, telephone number of my new adjuster.

I agree to waive the statute of limitation for the services you provided to me pursuant to Code of Civil Procedure Section 360.5.

Should any party fail to abide by the terms of this agreement and suit be filed to enforce any term or condition, the prevailing party shall be entitled to reasonable adjuster fees.

This agreement shall be inuring to the benefit and be binding upon the heirs, successors or assigns of the parties. This agreement shall be deemed made and accepted at DuPage Healthcare, Ltd. for any action on this lien shall lie in the county of the treatment center which performed the service.

Patient's Signature: _____ **Date:** _____.

This agreement cannot be changed, altered or modified without written consent of the medical provider.

The undersigned, being adjuster of record for the above patient, does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect said medical provider above named prior to the payment of any part of such settlement, judgment, award, or verdict to the Patient named above.

I agree to notify you if I discontinue the patient in pursuit of their claim. I agree to provide you status of their claim upon your written request.

Adjuster's Signature: _____ **Date:** _____.

Adjuster: Please sign, date, and return the original to DuPage Healthcare, Ltd.'s office at once. Keep one copy for your records.