



DuPage Healthcare, Ltd.
LIVING WELL STARTS HERE

WORKERS COMPENSATION - 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

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

- | | | |
|--|--|--|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Confusion |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Lower Back Pain | <input type="checkbox"/> Pain shooting into the arm(s) |
| <input type="checkbox"/> Pain shooting into the leg(s) | <input type="checkbox"/> Numbness in your feet | <input type="checkbox"/> Numbness in your hands |
| <input type="checkbox"/> Difficulty sleeping | | |

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?

Work Injury Information

What is the date of your injury? _____ **Claim #** _____

Where do you work? _____

Did you report this to your employer? Yes No- You will need to

Name of supervisor you reported your injury to: _____

Supervisor's Phone # and Ext. _____ **Email:** _____

Insurance Adjustor's Information

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

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

Email: _____

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:** _____

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?

- | | | |
|--|---|---|
| <input type="checkbox"/> Routine medical | <input type="checkbox"/> Medications | <input type="checkbox"/> Emergency room |
| <input type="checkbox"/> Exercise | <input type="checkbox"/> Nutrition/Diet | <input type="checkbox"/> Holistic Care |
| <input type="checkbox"/> None of the above | | |

How have others been affected by your condition?

- | | |
|---|---|
| <input type="checkbox"/> They tell me to do something | <input type="checkbox"/> They are tired of me complaining |
| <input type="checkbox"/> Haven't notices any problems | <input type="checkbox"/> None of the above |

How did these methods work for you?

- | | | |
|---|---|--|
| <input type="checkbox"/> Bad Results | <input type="checkbox"/> Some Results | <input type="checkbox"/> Great Results |
| <input type="checkbox"/> Results Did Not Last | <input type="checkbox"/> Symptoms Stayed the Same | <input type="checkbox"/> No Changes |
| <input type="checkbox"/> Still Trying | <input type="checkbox"/> I'm Confused/Frustrated | <input type="checkbox"/> None of the above |

What areas of your life has this problem affected?

- | | | |
|---|---|---|
| <input type="checkbox"/> My job | <input type="checkbox"/> My marriage/relationship | <input type="checkbox"/> My sleep |
| <input type="checkbox"/> My self-esteem | <input type="checkbox"/> My independence | <input type="checkbox"/> My household work |
| <input type="checkbox"/> My recreational activities | <input type="checkbox"/> My social life | <input type="checkbox"/> Playing with my kids |
| <input type="checkbox"/> Playing with my grandkids | <input type="checkbox"/> Ability to exercise | <input type="checkbox"/> None of the above |

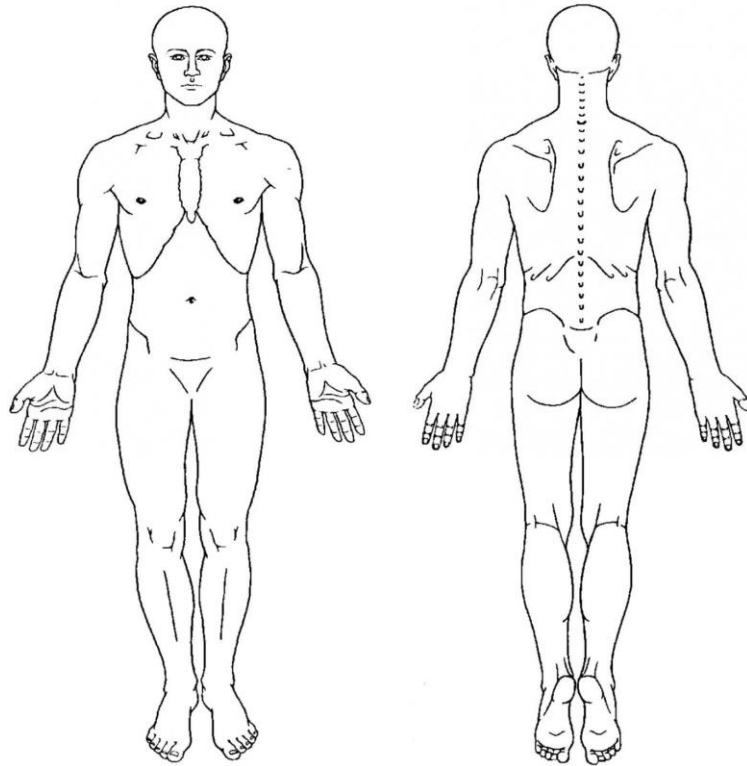
If left untreated and your condition worsens, where do you see yourself in 1-2 year?

- | | | |
|-------------------------------------|--|---|
| <input type="checkbox"/> Surgery | <input type="checkbox"/> More Medication | <input type="checkbox"/> Hospitalization |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Loss of work | <input type="checkbox"/> Loss of independence |
| <input type="checkbox"/> Disability | <input type="checkbox"/> None of the above | |

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.

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

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: _____

Date of birth: _____

Last Name: _____

Social Security: _____

Relationship to the patient: _____

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: _____



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 awaiting payment. I further understand that such payment is not contingent on any settlement, judgment, or verdict by which I may eventually recover said 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.**