SpineGeek Chiropractic

Accident Insurance Information

Patient Name ____
Insured Name_______________________________ Relationship to Insured ________________
Name of Insurance Company ____
Insurance Company Phone # ____
Claim # ____ Date of Accident ___/___/______
Adjusters Name and # ____
Do you have a Preferred Provider Organization (PPO)? Yes / No
Please tell us about your accident:
____
____
____
____

I understand that the above information is required for filing a claim with my insurance company and I will be responsible for full payment of my account.

Assignment & Instruction for Direct Payment to SpineGeek Chiropractic

I hereby instruct and direct ______________________ Insurance Company to make the check payable to the name and address below. If my current policy prohibits direct payment to the doctor, I hereby also instruct and direct you to make the check payable to me as follows:

Joseph S. Arvay, DC, PC
SpineGeek Chiropractic
10673 Melody Drive
Northglenn, CO 80234

For the professional of medical expenses allowable, and otherwise payable under me under my current insurance policy as payment towards the total charges for the professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND UNDER THIS POLICY. 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 charges over and above insurance payment.

I also authorize the release of any information pertinent to my case to any insurance company, or attorney involved in this case. I authorized the doctor to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

____ ____
Signature of Policy Holder Date Witness Date

Today's Date _______________

Name _______________________________ Age _________ Date of Birth _________________
Address ____ City ________________________
State ______ Zip ____________ Phone _____________________ Cell _____________________
Sex: M / F Occupation __________________________________ Fax ____________________
SS# _____ - ____ - ______ Drivers Lic. # ____________________ Marital Status ______________
Name of Spouse ___________________________________ Years Married _________________
Number of Children _______ Name(s) & Age(s) _______________________________________
____

System Review

Please enter in front of the following signs and symptoms:
1 = Never. 2 = I used to have it. 3 = I have it now.

GENERAL SYMPTOMS

_______ Headache
_______ Fever
_______ Chills
_______ Night Sweats
_______ Fainting
_______ Dizziness
_______ Convulsions
_______ Loss of Sleep
_______ Fatigue
_______ Nervousness
_______ Loss of Weight
_______ Numbness or Pain in
_______ Arms/Legs/Hands
_______ Allergies
_______ Wheezing

MUSCLE & JOINTS

_______ Weakness
_______ Twitching
_______ Stiff Neck
_______ Backache
_______ Swollen Joints
_______ Tremors
_______ Foot Trouble
_______ Painful Tail Bone
_______ Shoulder Pain
_______ Hernia
_______ Scoliosis

GASTRO-INTESTINAL

_______ Poor Appetite
_______ Poor Digestion
_______ Excessive Hunger
_______ Belching or Gas
_______ Nausea
_______ Vomiting
_______ Vomiting Blood
_______ Stomach Pain
_______ Constipation
_______ Diarrhea
_______ Colon Trouble
_______ Hemorrhoids
_______ Liver Trouble
_______ Jaundice
_______ Gall Bladder Pain

CARDIO VASCULAR

_______ Rapid Heart
_______ Slow Heart
_______ High Blood Press.
_______ Low Blood Press.
_______ Varicose Veins
_______ Pain Over Heart
_______ Heart Trouble
_______ Swelling of Ankle
_______ Poor Circulation
_______ Strokes

EYES, EARS, NOSE, THROAT

_______ Poor Vision
_______ Crossed Eyes
_______ Pain in Eyes
_______ Deafness
_______ Earache
_______ Ear Noises
_______ Ear Discharge
_______ Nasal Obstruction
_______ Nose Bleed
_______ Sore Throat
_______ Hoarseness
_______ Hay Fever
_______ Asthma
_______ Frequent Colds
_______ Enlarged Thyroid
_______ Tonsillitis
_______ Sinus Trouble

SKIN OR ALLERGIES

_______ Skin Eruptions
_______ Itching
_______ Bruise Easily
_______ Dryness
_______ Boils
_______ Sensitive Skin
_______ Hives or Allergies
_______ Eczema

RESPIRATORY

_______ Chronic Cough
_______ Spitting Blood
_______ Spitting Phlegm
_______ Chest Pain
_______ Breathing Problems

GENITO-URINARY

_______ Frequent Urination
_______ Blood In Urine
_______ Kidney Infection
_______ Bed Wetting
_______ Inability to Control Urine
_______ Prostate Trouble
_______ Painful Urination

FOR WOMEN ONLY

_______ Painful Periods
_______ Excessive Flow
_______ Irregular Cycles
_______ Hot Flashes
_______ Cramps or Back Pain
_______ Miscarriage
_______ Pregnant at this time

Mark any of the following that apply currently to your life:

HABBITS	EXERCISE
___ Smoking	___ None
___ Drinking Alcohol	___ Moderate
___ Coffee	___ Daily

Have you had any of the following diseases?

___ Appendicitis	___ Anemia	___ Heart Disease	___ Arthritis
___ Pneumonia	___ Measles	___ Goiter	___ Epilepsy
___ Rheumatic Fever	___ Mumps	___ Influenza	___ Mental Disorder
___ Polio	___ Chicken Pox	___ Pleurisy	___ Eczema
___ Tuberculosis	___ Diabetes	___ Alcoholism	___ Glaucoma
___ Whooping Cough	___ Cancer	___ Degenerative Disc	___ Fibromyalgia

Operations and Procedures (Date any of the following that you have had):

________ Tonsillectomy	________ Tubes in Ears	________ Sinus
________ Gall Bladder	________ Appendectomy	________ Hernia
________ Back	________ Female Organs	________ Thyroid
________ Stomach	Any Others That Are Not Listed	___________________________

List of any accidents or falls (Please date):

Car ______________________________________	Motorcycle _______________________________
Sport ____________________________________	School ___________________________________
Work ____________________________________	Other ___________________________________

Have you ever broken any bones? (Please list and date) ___________________________________

Have you ever been on crutches? Y / N Why? ____

Have you ever had any spinal injections? Y / N Ever knocked unconscious: Y / N

Current History:

Where do you hurt? ____

What does it feel like? ________________________ When does it hurt? _______________________

What caused this? ___________________________ When does it happen? ___________________

Is this interfering with: **Sleep?** Y / N **Work?** Y / N **Daily Activity?** Y / N **Exercise?** Y / N **Life?** Y / N

Who are you seeing now for this? ____

When was your last visit? ___________ What did they do? __________________________________

List anyone else you have seen for this: ____

Please list all medications (type/purpose): ____

Family History:

	DIABETES	HEART	KIDNEY	CANCER	BACK TROUBLE
MOTHER	_______	_______	_______	_______	_______
FATHER	_______	_______	_______	_______	_______
BROTHER	_______	_______	_______	_______	_______
SISTER	_______	_______	_______	_______	_______

Accident Information:

What happened? ____
When? ___________ Who was driving? ____________________________ Seat belt on? Y / N
Were there other passengers? Y / N Who? ____

Describe the accident: ____
____
____
____

What have you done to get better since? ____
____
____
____

On a scale of 1 to 10 (1 meaning no pain, 10 meaning that you need to go to the emergency room:

What was your level of pain? ___________________

What is your current level of pain? ______________

How has this affected you at work? ______________

How has this affected you at home? _____________

How has this affected your relationships? ____
____
____
____

What can't you do now that you could do before the accident? _________________________
____
____
____

Do you feel the same as you did before the accident? ___________________________________
____
____
____

Patient Name: ____ Date: _____________

Activities of Daily Living/Symptoms/Medications

Effects of Current Conditions on Performance

Please identify how your current condition is effecting your ability to carry out activities that are routinely part of your life:

Bending	◯ No Effect	◯ Painful (can do)	◯ Painful (limits)	◯ Unable to Perform
Concentrating	◯ No Effect	◯ Painful (can do)	◯ Painful (limits)	◯ Unable to Perform
Doing Computer Work	◯ No Effect	◯ Painful (can do)	◯ Painful (limits)	◯ Unable to Perform
Gardening	◯ No Effect	◯ Painful (can do)	◯ Painful (limits)	◯ Unable to Perform
Playing Sports	◯ No Effect	◯ Painful (can do)	◯ Painful (limits)	◯ Unable to Perform
Recreational Activities	◯ No Effect	◯ Painful (can do)	◯ Painful (limits)	◯ Unable to Perform
Shoveling	◯ No Effect	◯ Painful (can do)	◯ Painful (limits)	◯ Unable to Perform
Sleeping	◯ No Effect	◯ Painful (can do)	◯ Painful (limits)	◯ Unable to Perform
Watching TV	◯ No Effect	◯ Painful (can do)	◯ Painful (limits)	◯ Unable to Perform
Carrying	◯ No Effect	◯ Painful (can do)	◯ Painful (limits)	◯ Unable to Perform
Dancing	◯ No Effect	◯ Painful (can do)	◯ Painful (limits)	◯ Unable to Perform
Dressing	◯ No Effect	◯ Painful (can do)	◯ Painful (limits)	◯ Unable to Perform
Lifting	◯ No Effect	◯ Painful (can do)	◯ Painful (limits)	◯ Unable to Perform
Pushing	◯ No Effect	◯ Painful (can do)	◯ Painful (limits)	◯ Unable to Perform
Rolling Over	◯ No Effect	◯ Painful (can do)	◯ Painful (limits)	◯ Unable to Perform
Sitting	◯ No Effect	◯ Painful (can do)	◯ Painful (limits)	◯ Unable to Perform
Standing	◯ No Effect	◯ Painful (can do)	◯ Painful (limits)	◯ Unable to Perform
Working	◯ No Effect	◯ Painful (can do)	◯ Painful (limits)	◯ Unable to Perform
Climbing	◯ No Effect	◯ Painful (can do)	◯ Painful (limits)	◯ Unable to Perform
Doing Chores	◯ No Effect	◯ Painful (can do)	◯ Painful (limits)	◯ Unable to Perform
Driving	◯ No Effect	◯ Painful (can do)	◯ Painful (limits)	◯ Unable to Perform
Performing Sexual Activities	◯ No Effect	◯ Painful (can do)	◯ Painful (limits)	◯ Unable to Perform
Reading	◯ No Effect	◯ Painful (can do)	◯ Painful (limits)	◯ Unable to Perform
Running	◯ No Effect	◯ Painful (can do)	◯ Painful (limits)	◯ Unable to Perform
Sitting to Standing	◯ No Effect	◯ Painful (can do)	◯ Painful (limits)	◯ Unable to Perform
Walking	◯ No Effect	◯ Painful (can do)	◯ Painful (limits)	◯ Unable to Perform

Motor Vehicle Accident Questionnaire

The following questions will help us in putting your corrective care plan together:

1. What was the height of the headrest in the seat you were in at the time of the accident?

______ Low ______ Midway up ______ All the way up ______ No headrest

2. Did you see the vehicle coming before it hit you or were you unaware that you were about to be hit?

______ Saw it coming ______ Was unaware of it coming

3. What position was your head in at the time of the impact? ____________________________
____

4. What was the type and size of the car you were in? __________________________________

5. What was the type and size of the car that hit you? __________________________________

6. Was your vehicle or the other vehicle carrying anything heavy (i.e. car full or truck full of anything)? ____

7. Did you have your seatbelt on? ______ Yes ______ No

8. Did you have any type of pain IMMEDIATELY after the accident?

______ Yes ______ No Where? ____

SpineGeek Chiropractic
Joseph S. Arvay DC, PC
10673 Melody Drive
Northglenn, CO 80234

Doctor's Lien

To:
____
____
____

Authorization for release of records and doctor's lien, assignment and direction to my attorney.

I hereby authorize SpineGeek Chiropractic to furnish you, my attorney, with a full report and records regarding my case history, examination, diagnosis, treatment, and prognosis with regards to treatment related to my motor vehicle accident.

I hereby give a lien and assignment to SpineGeek Chiropractic on the proceeds or any settlement, claim, judgment or verdict which results from said accident and hereby authorize, direct and instruct you, my attorney, to pay directly to SpineGeek Chiropractic such sums as may be due and owing for service rendered me, and to withhold such sums from settlement, claim, judgment or verdict as may be necessary to protect SpineGeek Chiropractic any outstanding balance owed at the time of distribution of funds from any settlement, claim, judgment or verdict.

I fully understand that I am directed and fully responsible to SpineGeek Chiropractic for all bills submitted by SpineGeek Chiropractic for services rendered to me, and that this agreement is solely for SpineGeek Chiropractic's additional protection and in consideration of said Doctors awaiting payment, I further understand that such payment is not contingent on any settlement, claim, judgment, or verdict which I may eventually recover.

I fully understand that the lien given to SpineGeek Chiropractic herein is irrevocable.

To my attorney: I direct that you be bound by this lien and treat it irrevocably as an assignment to SpineGeek Chiropractic of any sum that may be due to me, to the extent and according to the term sum set forth above, be advised that SpineGeek Chiropractic is relying upon this lien, assignment, and directive to you, and as a result of such reliance, at my request, is providing chiropractic care and treatment for which this lien, assignment and directive to you provides security for payment. Moreover, it is my intention that SpineGeek Chiropractic be viewed as a 3rd party beneficiary of this direction to you, and I intend thereby to impose upon you an obligation to SpineGeek Chiropractic to comply with the terms of this direction to you.

____________________________________	____________________________________
Date	Patient's Signature / Print Patient's Name
____________________________________	____________________________________
Witness	Attorney Signature / Print Attorney's Name

Dr. Arvay's office communicates office closures, appointment reminders and event notices via text message and email. Please advise which cell phone number and email would be best for these communications. This will enable us to serve you better.

Cell Phone #: ____

Email: ____

Full Name: ____

Birthday: ___/___/_______

Signature: ____ Date: __________________

Normal texting/data charges as imposed by your carrier will apply.

JDD, DC 5/2011

FOR OFFICE USE ONLY.

Perfect Patients Emails Refersion

Staff Signature

____

Dr. Joseph S. Arvay DC / Spinegeek Chiropractic
10673 Melody Drive Northglenn CO 80234 / 303.457.8080