Corsello Clinic of Chiropractic

ACCIDENT INTAKE FORMS → *Please print clearly!*

Patient's Last Name__________________ First Name________________ Nickname________ Sex □ M □ F

Social Security Number ____/____/_____ Driver's License #_____________ Date of Birth ___/___/_____

Patient's Address____
(Number) (Street) (City) (State) (Zip)

Home Phone____________________ Cell Phone__________________ Native Language________________

Email Address___________________________ (*If you have one, please make sure we have this, thanks!*)

Patient's Employer______________________________ □ Full time □ Part time □ Retired □ Student

Employer Address____ Work Phone_______________________

□ Married □ Single □ Divorced □ Widowed Spouse's Name___________# of Children_______

Height ________ Weight _______ Blood Pressure _____/_____ Race/Ethnicity ___________________________

*******REFERRED BY______________________________ RELATIONSHIP____________ (VERY IMPORTANT!)*******

Insurance Information – Please provide copies of all policies/cards you carry.

AUTO ACCIDENT → provide your auto insurance, their auto insurance & your health insurance

Your Auto Insurance – please provide copy of insurance verification

Auto Insurance Company_________________________________ Policy #___________________________

Claims Address ____

Claims Phone#________________________________ Claim # (if assigned) __________________________

Adjuster/Contact Person _________________________ Phone # ___________________________________

Do you have MedPay on your car insurance policy? □ Yes □ No □ Not Sure

Their Auto Insurance – please provide copy of insurance verification

Auto Insurance Company_________________________________ Policy #___________________________

Claims Address ____

Claims Phone#________________________________ Claim # (if assigned) __________________________

Adjuster/Contact Person _________________________ Phone # ___________________________________

Your Health Insurance – please provide copy of insurance card

Company Name_______________________ Policy #____________________ Group #_________________

Claims Address ____

Claims Phone #________________________________ Insured's Name ______________________________

Insured's Date of Birth _________________________ Insured's Relationship to Patient _________________

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WORK INJURY → provide copy of Worker's Compensation insurance & your health insurance

Worker's Compensation Insurance

Insurance Company Name________________________________ Policy #______________________________

Claims Address ____

Claims Phone#__________________________________ Claim # (if assigned) ____________________________

Adjuster/Contact Person __________________________ Phone # _____________________________________

Your Health Insurance

Company Name________________________ Policy #_____________________ Group #_________________

Claims Address ____

Claims Phone #__________________________________ Insured's Name _______________________________

Insured's Date of Birth __________________________ Insured's Relationship to Patient _________________

Accident Information

Date and time the accident occurred: ____ /____ /______, ___:____ □ **AM** □ **PM**

Please explain in detail how the accident occurred.

____

____

____

____

Do you have an attorney? □ Yes □ No **If not, do you plan to retain one?** □ Yes □ No

Name of Attorney ______________________________________ Law Firm ________________________________

Phone # ________________________________ Address ____

Please draw what happened in this accident:

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FOR AUTO ACCIDENTS ONLY (For Work-Related or Slip/Fall Accidents, continue on Page 4):

Driving conditions at time of accident: □ Day □ Night □ Dusky □ Dry □ Wet □ Damp □ Paved □ Gravel □ Other ____________________

Year, Make & Model of your vehicle _____________Year, Make & Model of other vehicle_____________

Approximate speed vehicles were traveling at time of impact: Yours ______MPH Theirs ______MPH

Were your brakes applied? □ Yes □ No. If Yes, □ Hard □ Lightly

Were you forewarned of impact at all? □ Yes □ No, Explain ______________________________________

What was your position in the vehicle? □ Driver □ Passenger (Name of Driver: _____________________ Your Relationship to Driver: ________________________________)

If passenger, were you setting in: □ Front □ Right Rear □ Left Rear □ Other ______________________

At time of impact were you: □ Looking straight ahead □ To the right □ To the left □ Up □ Down

Were both hands on the steering wheel? □ Yes □ No, Explain ___________________________________

Was your foot on the brake? □ Yes □ No □ N/A Were you braced for impact? □ Yes □ No

Was your seat back reclined? □ Yes □ No Was your body posture: □ Straight □ Slouched

Were you wearing seat belts? □ Yes □ No Shoulder harness □ Yes □ No

Headrests were: □ Present but <u>not</u> adjusted for my height □ Present <u>and</u> adjusted for my height □ There were none □ I don't recall

What was the approximate distance between your head and the headrest? ________ inches

Did airbag inflate? □ Yes □ No □ Not equipped

Where in the vehicle/outside of the vehicle were you after the impact? ___________________________

Did you strike anything in the vehicle at impact? □ Yes □ No If yes, please specify: □ Steering wheel □ Dashboard □ Windshield □ Side door □ Armrest □ Side window □ Other: _____________________

Please state the part of your body that hit: □ Left □ Right □ Chest □ Chin □ Knee □ Shoulder □ Hand □ Head □ Face □ Other: __________________________

Were you wearing glasses or a hat? □ Yes □ No □ Something else: ______________________________

If yes, were they still on following the accident? □ Yes □ No

What was the position of your hands/arms at the time of impact? _________________________________

What were your movements following the collision? □ Back, then forward □ Forward, then back

□ Left side to right side □ Right side to left side □ Other: ____

Approximate cost of repairs for vehicle damage: $____________ Was your vehicle totaled? □ Yes □ No

******Please email photos of (1) you positioned in your vehicle as you were at time of impact AND (2) the damage to your vehicle (if available) to us at contact@corselloclinic.com.**

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FOR ALL ACCIDENTS (AUTOMOBILE, WORK-RELATED, SLIP/FALL) → CONTINUE HERE!

Immediately following the accident, how did you feel? ____

Where did you go? ____

Were you unconscious? □ Yes □ No In a daze? □ Yes □ No

Did you go to the hospital? □ Yes □ No If yes, when? □ At time of accident □ Next day
□ Other ____

How did you get to the hospital? □ Ambulance □ I drove myself □ Driven by: ____________________

Did the ambulance attendants place you in: □ Neck collar □ Splints □ Brace □ Other: ____________

Name of the Hospital ____________________________ Attended by Dr. ____________________________

Were x-rays taken at the hospital? □ Yes □ No If yes, what body part(s)? ______________________

Were you admitted to the hospital? □ Yes □ No If yes, how long did you stay? __________________

What treatment was rendered? ____

What recommendations were made? ____

Have you seen any other Doctor because of this accident? □ Yes □ No

If yes, Doctor(s) Name _____________________________ Specialty _____________________________

When were you first seen by the doctor above? ____

Who referred you? ______________________ What treatment was rendered? _________________________

Are you still under care there? □ Yes □ No

If yes, what are the doctor's plans? ____

If no, why did you discontinue? ____

Please list all medications you currently take. ____

____

Is your pain: □ Constant □ On and off □ Sharp □ Dull □ Other ______________________________

Is your pain worse: □ Arising from chair □ Straining □ Coughing □ Sneezing □ When moving bowels

Do you have any numbness or tingling in your: □ Arms □ Hands □ Fingers □ Legs □ Feet □ Toes
□ Other _______________________________

What is your most comfortable position? □ Sitting □ Laying on right side □ Laying on left side

□ Laying on your back □ Laying on your stomach □ Standing □ Other ____________________________

Is it difficult to move around in bed? □ Yes □ No

Does stretching or twisting worsen the pain? □ Yes □ No

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Do any of the following relieve your pain? □ Heating pad □ Hot bath □ Shower □ Ice pack
□ Medicines (specify) ____

Does a change in heel height worsen the pain? □ Yes □ No

Do you feel better moving around? □ Yes □ No Or resting? □ Yes □ No

Do you have a firm mattress? □ Yes □ No

Do your knees ache or hurt? □ Yes □ No Do you have leg cramps? □ Yes □ No

Arm cramps? □ Yes □ No Have you had any change in your bowel habits? □ Yes □ No

Have you lost any time from work because of this accident? □ Yes □ No

If yes, give dates of time lost: From ____/____/______ To ____/____/______

Totally disabled: From ____/____/______ To ____/____/______

Partially disabled: From ____/____/______ To ____/____/______

Are you presently able to lift:

□ Very heavy _____lbs. □ Heavy ____lbs. □ Light ____lbs. □ Sitting ____lbs.

With minimum demand of physical effort, what positions can you work in and for how long?

□ Standing (if any restriction, describe) ______________________________________

□ Walking (if any restriction, describe) ______________________________________

□ Sitting (if any restriction, describe) ______________________________________

Do you feel that you cannot perform <u>any</u> physical work activity? □ Yes □ No

Do you feel that you cannot perform <u>any</u> mental work? □ Yes □ No

Relate your BEFORE injury capacity (mark "B") and your AFTER injury capacity (mark "A") for performing activities:

Walking	Normal __________	Limited __________	Difficult _________	Pain ____________
Standing	Normal __________	Limited __________	Difficult _________	Pain ____________
Sitting	Normal __________	Limited __________	Difficult _________	Pain ____________
Bending	Normal __________	Limited __________	Difficult _________	Pain ____________
Stooping	Normal __________	Limited __________	Difficult _________	Pain ____________
Lifting	Normal __________	Limited __________	Difficult _________	Pain ____________
Pushing	Normal __________	Limited __________	Difficult _________	Pain ____________
Pulling	Normal __________	Limited __________	Difficult _________	Pain ____________
Climbing	Normal __________	Limited __________	Difficult _________	Pain ____________
Reaching	Normal __________	Limited __________	Difficult _________	Pain ____________
Gripping	Normal __________	Limited __________	Difficult _________	Pain ____________
Kneeling	Normal __________	Limited __________	Difficult _________	Pain ____________
Balance	Normal __________	Limited __________	Difficult _________	Pain ____________
Fatigue	Normal __________	Limited __________	Difficult _________	Pain ____________

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Are you able to take personal care of yourself, such as dressing, bathing, etc.? □ Yes □ No
If Yes, please describe: ____

Are any of your other activities of daily living affected by this accident? (Check all that apply.)

□ Walking □ Exercise □ Recreational activities □ Sleeping □ Driving □ Sexual activity □ Caring for children □ Other, please describe: ____

Past Medical History

□ This is the first time I am experiencing these complaints.

□ I have experienced the same or similar complaints before. Please explain:

____

List any prior accidents, surgeries, diseases, or serious illnesses you have had (include dates):

____

Family History

□ Tuberculosis	□ Kidney Disease	□ Spinal Disorder	□ Mental Illness
□ Epilepsy	□ Arthritis	□ Cancer	□ Allergy
□ Migraines	□ Gout	□ Heart Attacks	□ Hypertension
□ Diabetes	□ Dementia/Alzheimer's	□ Other: ____________	□ Other: ____________

Please mark any of these signs of malfunction you currently have and/or have had since the accident:

Musculo-Skeletal	**Genito-Urinary**	**Gastro-Intestinal**	□ Gall Bladder Problems
□ Neck Pain	□ Bladder Trouble	□ Poor Appetite	□Weight Changes
□ Mid Back Pain	□ Excessive Urination	□ Excessive Hunger	**Nervous System**
□ Low Back Pain	□ Scant Urination	□ Difficulty Chewing	□ Numbness
□ Pain Between Shoulders	□ Painful Urination	□ Difficulty Swallowing	□ Loss of Feeling
□ Shoulder Pain	□ Discolored Urine	□ Excessive Thirst	□ Paralysis
□ Arm/Elbow Pain		□ Nausea	□ Dizziness
□ Hand/Wrist Pain	**Female**	□ Vomiting Blood	□ Fainting
□ Pelvic/Hip Pain	□ Vaginal Discharge	□ Abdominal Pain	□ Headaches
□ Knee Pain	□ Vaginal Bleeding	□ Diarrhea	□ Muscle Jerking
□ Leg/Ankle Pain	□ Breast Pain	□ Constipation	□ Convulsions
□ Swollen, Painful or Stiff Joints	□ Lumps on Breast	□ Black or Bloody Stool	□ Depression
□ Sore or Weak Muscles	**Male**	□ Hemorrhoids	□ Insomnia
□ Broken Bones	□ Bladder Dysfunction □ Sexual Dysfunction	□ Liver Trouble	□ Other: ____________

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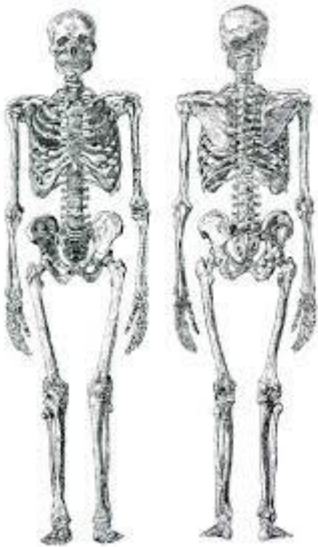
Eye, Ear, Nose and Throat	□ Nose Pain	**Cardio-Vascular/Respiratory**	□ Low Blood Pressure
□ Eye Strain	□ Nose Bleeding	□ Chest Pain	□ Heart Problems
□ Eye Inflammation	□ Nasal Discharge	□ Pain over Heart	□ Lung Problems
□ Vision Problems	□ Difficulty Breathing Through Nose	□ Difficulty Breathing	□ Blood Clots
□ Ear Pain	□ Dental Problems	□ Persistent Cough	**Habits**
□ Ear Ringing	□ Sore Throat	□ Coughing Phlegm	□ Smoking
□ Ear Discharge	□ Difficult Speech	□ Rapid Heartbeat	□ Alcohol Abuse
□ Hearing Loss	□ Jaw Pain	□ High Blood Pressure	□ Drug Abuse

Please mark areas of pain on figures below:



Are you pregnant? □ Yes □ No □ Maybe

Consent of Professional Services and Release of Information

I hereby authorize and release the doctor and whomever he may designate as his assistants, to administer treatment, physical examination, x-ray studies, laboratory procedures, chiropractic care, and any clinic services that he deems necessary in my case. I further authorize him to disclose all or part of my patient's records to any person or corporation which is or may be liable under a contract to the clinic or to a family member or employer for all or part of the clinic's charges, including, but not limited to, hospital or medical services companies, insurance companies, worker's compensation carriers, welfare funds, or my employer.

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. Furthermore, I understand that this chiropractic office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount is to be paid directly to this chiropractic office and will be credited to my account upon receipt. Patient authorizes the doctor to endorse any and all drafts on behalf of the patient and credit that amount to the patient's account.

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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 terminate my care or treatment, any fees for professional services rendered to me will be immediately due and payable.

Patient Signature ____ Date ______________________

Signature of Parent or Guardian Authorizing Care________________________ Date _______________

<u>Basic Office Policies</u>

1. All first visit charges are payable when services are rendered. (see #3)
2. The fee paid for treatment x-rays is for the analysis only. The x-ray itself is the property of the office. Once x-rays are used for treatment purposes, they cannot be released. Copies can be emailed if requested by another physician.
3. Method of payment you plan to use to take care of first visit charges, please check one:
   □ Cash □ Check □ Credit Card □ Gift Card
4. I understand and agree that health and accident insurance policies are an arrangement between my insurance carrier and me. Furthermore, I understand the Corsello Clinic of Chiropractic will prepare any necessary reports and forms to assist in making collections from the insurance company, and that any amount authorized to be paid directly to the Corsello Clinic of Chiropractic or Dr. Edward Corsello 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.
5. ***I also understand that if I suspend or terminate my care at this office, any and all outstanding charges for professional services rendered to me will be <u>immediately</u> due and payable.*** I agree that I will be responsible for all attorney and legal fees if legal action becomes necessary to collect my account. I authorize Corsello Clinic of Chiropractic to obtain a credit report if deemed necessary. (In other words, I promise to pay my bill.☺)

Patient Signature ____ Date ______________________

Signature of Parent or Guardian Authorizing Care________________________ Date _______________

<u>Emergency Contact Information:</u>

In case of emergency, please notify ____________________________________ (First and Last Name)

Relationship to patient ___________________________________ Phone Number __________________

<u>Release and Assignment of Medical Payment Benefits</u>

The parties appearing below, on this ___(day) day of ______________ (Month), ______ (Year), hereby agree to the following conditions, covenants, and terms regarding the benefits appearing in the policy belonging to _____________________________ (Name) issued by ___________________ (Ins. Co.).

I, _____________________________________ (Name) hereafter referred to as "patient," understand and voluntarily agree to assign all applicable medical pay provisions appearing in my insurance policy named above directly to the doctor.

The patient request, orders, and directs _____________________________ (Insurance Carrier) to pay the doctor directly at his office at 2021 Main Street, Stratford, CT 06615 the sums due to the doctor for treatment which occurred on or after the ___ (day) day of ___________ (Month), ______ (Year).

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The patient gives the doctor the exclusive right to secure the funds assigned by the patient, including the right of securing consent to represent the doctor in collecting all sums due for treatment rendered as well as any and all collections costs and fees. Patient authorizes the doctor to endorse any and all drafts on behalf of the patient and credit that amount to the patient's account.

That doctor and patient hereby enter into this agreement of benefits freely and voluntarily as evidenced by the signatures appearing below; that patient and the doctor warrant that they have read this assignment of benefits and that each understands the legal effect of the same and agree that each shall be bound by the covenants, terms and conditions appearing herein.

I further authorize release of any information necessary to process my insurance claims and assign and request payment directly to Dr. Edward C. Corsello.

**Patient's/Guardian Signature____ Date: ___/___/______

Witness's Signature____ Date: ___/___/______

Consent to Evaluate and Treat a Minor Child (Under Age 18)

I ____________________________ (parent's name), being the parent or legal guardian of ____________________________(child's name) have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

**Parent/Guardian Signature____ Date: ___/___/______

<u>Privacy Practices – Patient Reception Form</u>

I have reviewed the Notice of Privacy Practices (3 pages) for The Corsello Clinic of Chiropractic, and understand the situations in which this practice may need to utilize or release my medical records. I also understand that I agreed to the use of those records when I submitted initial intake paperwork, whenever that may have occurred. I understand that this office will properly maintain my records, and will use all due means to protect my privacy as outlined in this privacy practices statement.

**Patient's/Guardian Signature____ Date: ___/___/______

<u>X-ray Consent</u>

Diagnostic x-rays may be advisable in my case so that a complete analysis can be made of my present musculoskeletal condition. I authorize Dr. Corsello to perform such radiographic examination necessary to diagnose and to administer whatever treatment is deemed necessary to treat my present condition.

**Patient's/Guardian Signature____ Date: ___/___/______

FOR WOMEN ONLY: To the best of my knowledge I am NOT pregnant and the above named Doctor has permission to perform x-rays for diagnostic interpretation.

**Patient's/Guardian Signature____ Date: ___/___/______

Thank you for completing these forms, and we look forward to serving you! ☺