SALL/MYERS MEDICAL – INTAKE INFORMATION FOR TREATING PATIENTS

Last Name _____ First _____ Initial _____

Today's Date _____ Date of Accident _____

Home Address _____

Home Phone # _____ Work # _____

Social Security # _____ Marital Status _____ # Children _____

Date of Birth _____ HT _____ WT _____ AGE _____ SEX _____

Parent/Guardian (If less than 18) _____

Highest Level of Schooling _____ What Country: _____

Were you employed at the time of the accident? _____ Where: _____

Describe your job: _____

Are you free to get treatment during the day? _____

Health Insurance: Carrier: _____ Address: _____

Insured: _____ Secondary Insurance _____

Attach a copy of identification card for each insurer listed.

PIP Insurance: Does the patient own a car? _____ Does anyone in the patient's household own a car? _____

If someone in the household owns a car, name of the insured _____

Has the accident been reported? _____ When? _____

Patients Carrier _____ Insured: _____

Address: _____

Relationship to the patient: _____

Policy # _____ Claim #: _____

Adjuster: _____ Phone: _____ Fax #: _____

Documentation required for all PIP Claims: (Copy all, front and back)

Insurance ID Card: _____ Declaration Page: _____ Police Report: _____

Driver's License: _____ Social Security Card: _____

Green Card: _____ Other: _____

Accident Information (Check all that apply. Describe accident in patient's own words)

Category: ☐ MVA ☐ Fall Down ☐ Treating Comp ☐ Other _____

Patient Was: ☐ Driver ☐ Front Passenger ☐ Rear Passenger ☐ Pedestrian

In a: ☐ Car ☐ Bus ☐ Truck ☐ Van ☐ Taxi ☐ Train ☐ Other _____

Were you wearing a seat belt? _____ Could the car be driven after the accident? _____

What is the first thing you remember after the accident? _____

Do you think you suffered a loss of consciousness at the time of the accident? _____

Description of exactly what happened to the patient at the time of the accident:

_____

_____

_____

_____

_____

_____

_____

_____

Injured Body Area:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Office:

- ☐ Paterson
- ☐ Irvington
- ☐ Hackensack
- ☐ New Brunswick
- ☐ Passaic
- ☐ Union City
- ☐ Plainfield

Social History:

Are you a smoker?

☐ Yes ☐ No

If yes, How often_____

Any Allergies to Medication?

☐ Yes ☐ No

If yes, please List_____

Specialty Requested:

- ☐ Orthopedist
- ☐ Neurologist
- ☐ Psychiatrist
- ☐ Physical Medicine & Rehab
- ☐ Internist

Report Type:

- ☐ New Patient
- ☐ Treating Comp
- ☐ Consultation
- ☐ Assumption of case from a referral source

Treatment given prior to this first visit at Sall/Myers:

Date: _____ Where: ☐ ER ☐ Dr. Office ☐ Hospital Clinic

Name and Address of first Medical Provider post accident: _____

Transported by: ☐ Car ☐ Ambulance ☐ Other _____

Treatment Given: ☐ Examination ☐ Ace Bandage ☐ Medicated ☐ Cervical Collar ☐ Sutures to _____

X-Rays/CT Scan (**be very specific and get reports of results faxed stat to our office**) _____

_____

Summarize all the treatment given to the patient prior to TODAY:

_____

_____

_____

Do you have any pain in any body part now that you did not have initially? _____ Where? _____

Impact on your quality of life at this time: _____

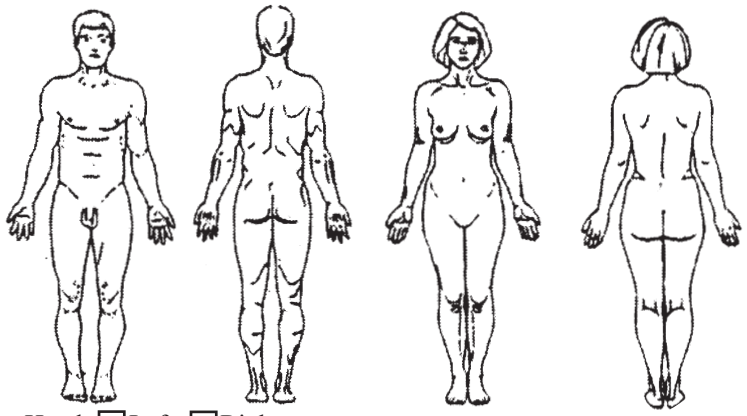
Does the pain make you:

☐ "Unable to work and earn an income" ☐ "Unable to function as a full time homemaker" ☐ "Unable to share in childcare duties" ☐ "Unable to get a good nights sleep" ☐ "Unable to go to school" ☐ "Unable to participate in sports" ☐ "Other" _____

TIME LOST FROM WORK (IF EMPLOYED) TO DATE: _____

Areas injured: (Indicate quality of pain on figure)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____



Medical (Co-Mobid) Conditions: (Check all that apply) Dominate Hand ☐ Left ☐ Right

☐ None ☐ Asthma ☐ Stroke ☐ Diabetes ☐ Allergies ☐ Hypertension ☐ Emphysema ☐ Seizure ☐ Heart Attack ☐ Ulcers ☐ Other: _____

Current Medications:

_____

_____

_____

_____

Prior Surgeries:

_____

_____

_____

_____

PREVIOUS ACCIDENTS AND/OR INJURIES (Must list every injured area that patient has received treatment)

Year	MVA/ or Fall Down	Body Part Injured	MRI Done (Yes or No)	Was a lawsuit filed?

Interviewed by: _____ ☐ Spanish ☐ English ☐ Other _____ Date _____

E-Mail _____ Patient's Signature _____ Date _____