

Name:
DOB:
Chart:
Age:
Date:



AUTOMOBILE ACCIDENT REPORT

NAME: _____ DATE OF ACCIDENT: _____ AGE: _____

LOCATION OF ACCIDENT (TOWN/STREET): _____

DETAILS OF ACCIDENT: _____

_____ WAS THE CAR TOTALLED? YES NO

WERE YOU THE DRIVER? YES NO PASSENGER?

DID THE AIR BAGS OPEN? YES NO WERE YOU UNCONSCIOUS AFTER THE ACCIDENT? YES NO

DID YOUR HEAD STRIKE ANY PART OF THE CAR? YES NO IF YES, WHAT PART? _____

WERE YOU WEARING A SEAT BELT? YES NO

DO YOU HAVE NECK PAIN? YES NO DOES THE PAIN GO DOWN YOUR HANDS? YES NO

IS THE PAIN GETTING ANY BETTER SINCE THE ACCIDENT? YES NO

DO YOU HAVE BACK PAIN? YES NO DOES THE PAIN GO DOWN YOUR LEGS? YES NO

IS THE PAIN GETTING ANY BETTER SINCE THE ACCIDENT? YES NO

DO YOU HAVE ANY OTHER INJURIES? YES NO WHERE? _____

DID YOU HAVE ANY MEDICAL TREATMENT THE DAY OF THE ACCIDENT? YES NO

WHERE? _____ HOW DID YOU GET THERE? _____

WERE XRAYS TAKEN? YES NO WHAT TREATMENT WAS PROVIDED? _____

DID YOU HAVE LATER CARE? YES NO WHERE? _____

WHAT TREATMENT WAS PROVIDED? _____

HAVE YOU HAD ANY HEADACHES? YES NO

BEFORE THIS ACCIDENT, DID YOU EVER HAVE BACK PAIN? YES NO

IF SO, WHAT WAS IT CAUSED BY? _____

BEFORE THIS ACCIDENT, DID YOU EVER HAVE NECK PAIN? YES NO

WHAT WAS IT CAUSED BY? _____

WHO IS YOUR ATTORNEY FOR THIS ACCIDENT? _____

ATTORNEY'S ADDRESS: _____

IS THERE MEDICAL COVERAGE UNDER YOUR AUTO POLICY OR THE CAR YOU WERE IN? _____

INSURANCE COMPANY NAME: _____ CLAIM # _____

ADDRESS: _____ PHONE # _____

CLAIMS ADJUSTER NAME: _____

Name:
DOB:
Chart:
Age:
Date:



PATIENT INFORMATION

PATIENT NAME: _____ SEX: _____

TELEPHONE #: HOME: _____ CELL: _____ WORK: _____

BIRTH DATE: _____ AGE: _____ EMAIL ADDRESS: _____

ADDRESS: _____
STREET CITY STATE ZIP CODE

SOCIAL SECURITY #: _____

CHECK APPROPRIATE: MINOR SINGLE MARRIED DIVORCED WIDOW

EMPLOYER: _____ TYPE OF WORK: _____

BUSINESS ADDRESS: _____

NAME OF SPOUSE: _____ NAME OF PARENT (IF MINOR): _____

SOCIAL SECURITY #: _____ BIRTH DATE: _____

EMPLOYER: _____ OCCUPATION: _____

BUSINESS ADDRESS: _____

HEALTH INSURANCE: YES NO

PRIMARY INSURANCE NAME AND ID #: _____

POLICY HOLDER OF PRIMARY INSURANCE: _____

SECONDARY INSURANCE NAME AND ID #: _____

POLICY HOLDER OF SECONDARY INSURANCE: _____

Please read the following, then sign and date at bottom of page:

To the extent necessary to obtain reimbursement, I authorize Eric J. Katz, MD to disclose any medical information to process this claim.

I hereby assign all medical and/or surgical benefits to which I am entitled, including Medicare, private insurance and other health plans to Eric J. Katz, MD, PC. In the event that my health insurance, workers' compensation or auto insurance does not pay for any or all medical services, I understand I will be personally responsible for payment of my bill.

I permit a copy of this authorization to be used in place of an original.

I have read and understand the Notice of Privacy Practices (Protected Health Information HIPAA regulations) as provided by his office.

Signature: _____ Date: _____

Name:
DOB:
Chart:
Age:
Date:



MEDICAL HISTORY FORM

NAME: _____ DATE: _____

NAME OF PRIMARY CARE PHYSICIAN _____ PHONE # OF PCP: _____

Height: _____ Weight: _____

ARE YOU ALLERGIC TO ANY MEDICATIONS? YES NO

IF YES, PLEASE LIST ALL MEDICATION AND REACTIONS: _____

PLEASE LIST ALL MEDICATIONS YOU ARE TAKING: _____

PLEASE LIST ANY SURGERIES WITH DATES: _____

REVIEW OF SYSTEMS

Have you had or do you have an ulcer? YES NO

Are you pregnant at this time? YES NO

Do you have any respiratory conditions? YES NO

Are you diabetic? YES NO

Do you have any skin ulcers or rashes? YES NO

Do you have a history of seizures, strokes or headaches? YES NO

Do you have a history of depression or nervousness? YES NO

Are you Anemic? YES NO

Have you had recent weight loss or loss of appetite? YES NO

Have you had or do you have any heart conditions (including HBP)? YES NO

Do you have any other medical conditions not listed above?

FAMILY HISTORY: Have any blood relatives had any of the following disorders?

Diabetes YES NO High Blood Pressure YES NO

Arthritis YES NO Heart Disease YES NO

Social History:

Do you smoke? YES NO Packs per day? _____

Alcohol use? YES NO How often? _____

The information is true and correct to the best of my knowledge:

Signature: _____ Date: _____