Name:
DOB:
Chart:
Age:
Date:

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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 <u>DAY</u> 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 INSRUACNCE 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?

<u>FAMILY HISTORY:</u> 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

<u>Social History:</u>

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: ______________