Name:
DOB:
Chart:
Age:
Date:

OrthoConnecticut
World-class care, close to home.

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 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?

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: _____