Medical Injury Solutions

1445 Old McDonough Rd, Ste. E, Conyers, Ga. 30094

Tel: 770-922-9222 Fax: 770-504-6318

NEW PATIENT INTAKE FORM—Personal Injury

PATIENT INFORMATION **CONFIDENTIAL**

Thank you for the opportunity to serve you. If you have any questions, do not hesitate to ask. We will be happy to help.

Name: _____ Date: _____/_____/_____ S/S:_____-_____-_____
First MI Last

Address: _____ City: _____ State: _____ Zip: _____

Contact Phone #: _____ Work #: _____ Email Address: _____

Birth Date: _____/_____/_____ Height: _____ Weight: _____

Sex: Female _____ Male _____ Married _____ Single _____ Divorced _____ Widow _____ Student _____

Your Employer: _____ Occupation: _____

Business Address: _____ City: _____ State: _____ Zip: _____

Spouse/Parent's Name: _____ Phone #: _____

Who may we thank for referring you to us? _____

Person to contact in case of emergency: _____ Phone #: _____

Your Auto Ins. Co.: _____ Policy #: _____ Claim #: _____

Name on Policy (**if not self**): _____ Responsible Party': _____

Agent's Name: _____ Phone #: _____

Address: _____ City: _____ State: _____ Zip: _____

Attorney's Name: _____ Phone #: _____

Address: _____ City: _____ State: _____ Zip: _____

At Fault Company **(if known)**: _____ Claim #: _____ Phone #: _____

ALL SERVICES RENDERED ARE THE FINANCIAL RESPONSIBILITY OF THE PATIENT. OUR OFFICE WILL FORWARD YOUR BILLS, AS A COURTESY TO THE APPROPRIATE ATTORNEY'S OFFICE OR 3RD PARTY LIABILITY INSURANCE COMPANY (AT FAULT PARTY'S INSURANCE). ULTIMATELY, WHETHER YOUR CASE SETTLES OR NOT, THE RESPONSIBILITY FOR SERVICES RENDERED IS YOUR OWN.

I HEREBY AUTHORIZE MEDICAL INJURY SOLUTIONS TO FURNISH INFORMATION TO PERTINENT INSURANCE CARRIERS CONCERNING MY ILLNESS AND TREATMENTS AND I HEREBY ASSIGN TO MEDCAL INJURY SOLUTIONS ALL PAYMENTS FOR MEDICAL SERVICES RENDERED TO MY DEPENDENTS OF MYSELF. I UNDERSTAND THAT THIS AUTHORIZATION WILL REMAIN IN EFFECT FOR AS LONG AS MY DEPENDENTS OR I REMAIN A PATIENT.

X_____ **DATE:** _____
(SIGNATURE OF PATIENT OR GUARDIAN)

I, _____, HEREBY CONSENT TO ALLOW THE FOLLOWING PERSON(S) ACCESS TO INFORMATION ON MY ACCOUNT THAT WOULD OTHERWISE BE CONSIDERED PROTECTED HEALTH INFORMATION (HIPPA);

_____

HEALTH HISTORY

PLEASE CHECK ANY OF THE FOLLOWING SYMPTOMS YOU HAVE NOTICED ***BEFORE THE ACCIDENT PLACE THE LETTER (B)*** OR ***AFTER THE ACCIDENT PLACE THE LETTER (A) IN THE BOX:***

	HEADACHES		IRRITABILITY		LOSS OF SMELL
	NECK PAIN		MOOD SWINGS		LOSS OF TASTE
	NECK STIFFNESS		SLEEPING PROBLEMS		UPSET STOMACH
	MID BACK PAIN		FATIGUE		CONSTIPATION
	LOW BACK PAIN		DEPRESSION		DIARRHEA
	ARM PAIN		CHEST PAIN		URINARY PROBLEMS
	LEG PAIN		SHORTNESS OF BREATH		HEARTBURN
	PINS AND NEEDLES IN ARMS		COLD SWEATS		ULCERS
	PINS AND NEEDLES IN LEGS		FEVER		ALLERGIES
	NUMBNESS IN FINGERS		FAINTING		MENSTRUAL PAIN
	NUMBNESS IN TOES		LOSS OF BALANCE		HOT FLASHES
	COLD HANDS		DIZZINESS		MENSTURAL IRREGULARITY
	COLD FEET		LIGHT SENSITIVITY WITH EYES		OTHER
	NERVOUSNESS		RINGING/BUZZING IN EARS		OTHER
	TENSION		LOSS OF MEMORY		

HAVE ***YOU (Y)*** or ***A FAMILY MEMBER (F)*** EVER BEEN DIAGNOSED WITH ANY OF THE FOLLOWING CONDITIONS?

	AIDS/HIV		HEART DISEASE		NONE
	CANCER		DIABETES		UNKNOWN
	HIGH BLOOD PRESURE		STROKE		OTHER

NATURE OF ACCIDENT:

Date of accident _____/_____/_____ Time of Day _____ Location of accident_____

Did you go to the **EMERGENCY ROOM?** _____ If YES, when? _____ Name of facility: _____

Relative speed of your car_____ (mph) Relative speed of the other car_____ (mph)

What was the site of impact on your car? Where were you sitting at the time of impact?

_____ Behind _____ Front _____ Driver

_____Driver's Side _____ Passenger's Side _____ Passenger….. _____ Front _____ Back

Were you wearing your seat belt? _____ Yes _____ No Did your air bags deploy? _____ Yes _____ No

Were your brakes applied? _____ Yes _____ No Did your seat back break? _____ Yes _____ No

PLEASE DESCRIBE THE ACCIDENT in your own words: _____

_____

_____

List any parts of your body that struck the following vehicle parts during the accident:

Dashboard: _____ Door: _____

Windshield: _____ Door Window: _____

Steering Wheel: _____ Other: _____

Your Vehicle Type: _____ Other Vehicle Type (if known): _____

Did you lose consciousness: _____ Yes (if yes, for how long) _____ _____ No _____ Unknown

ADDITIONAL INFORMATION:

What was your mental and emotional state immediately following the accident? _____

Were the police notified? _____ Did you receive medical attention at the scene of the accident? _____ Where did you go immediately after the accident? _____ Have you been treated by another doctor since this accident? _____

Please list the name of the doctor and address: _____

What type treatment did you receive? _____

Have you ever been involved in an accident before this one? _____ If yes, how long ago? _____

Have you lost time from work or school since the accident? _____ Last date attended worked/school: _____ Type of work you do? _____

PLEASE DESCRIBE HOW YOU FELT:

DURING the accident: _____

IMMEDICATLEY AFTER the accident: _____

LATER THAT DAY: _____

THE NEXT DAY: _____

Please add any other information that you feel is pertinent to this case:

_____

_____

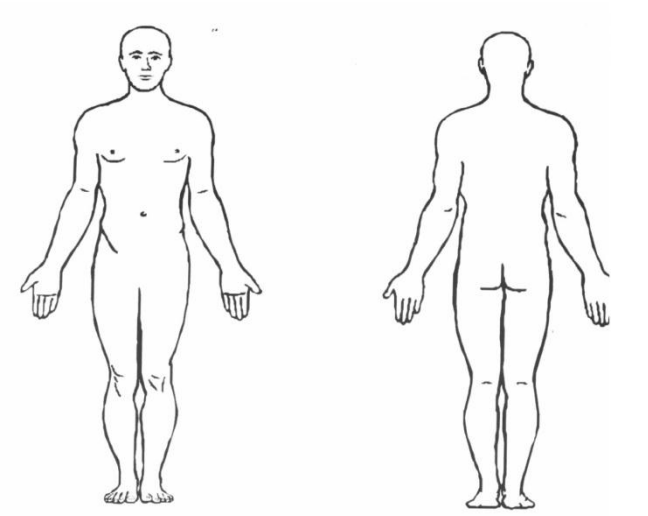
_____

PLEASE LIST YOUR CURRENT AREAS OF COMPLAINT:

(CHIEF COMPLAINT)

1) _____ 0 1 2 3 4 5 6 7 8 9 10 2) _____ 0 1 2 3 4 5 6 7 8 9 10 3) _____ 0 1 2 3 4 5 6 7 8 9 10 4) _____ 0 1 2 3 4 5 6 7 8 9 10

CIRCLE THE NUMBER THAT BEST DESCRIBES THE INTENSITY OF YOUR PAIN OF EACH CHIEF COMPLAINT: 1 = Mild, 10 = Severe



PLEASE USE THE DIAGRAM TO THE LEFT AND MARK THE AREAS OF THE BODY USING THE FOLLOWING KEY:

D = DULL
A= ACHING
S= STIFFNES
B= BURNING
T=TINGLING
N= NUMBNESS
!!= SHARP
X=SHOOTING

***= OTHER _____**

How often do you notice your symptoms? (*Please circle one*) ***Constantly*** ***Frequently*** ***Occasionally***

Does anything relieve your pain? _____

What activities are difficult to perform since your accident? (Please circle one) ***Sitting*** ***Standing*** ***Walking*** ***Bending*** ***Lying Down***

Please describe any other activities that are restricted due to this injury?

_____

Is the condition getting worse? _____ Have you had this problem before? _____ If yes, When? _____

Have you ever been diagnosed with a Subluxation? _____ If yes, When? _____

Have you had X-rays before? _____ If yes, When? _____ What body part? _____

What medications are you currently taking and for what reasons? If none, then leave blank.

_____

_____

Surgical History and dates: _____

Which best describes your health goals: (*please circle one*) ***pain relief only*** ***correct entire problem*** ***wellness/preventative care***

Medical Injury Solutions

MEDICATION AND PRESCRIPTION REFILL POLICY

1. **I agree to allow 48 hours for prescription refills.**
2. **I understand that prescription refills requested after 4:00 pm will not be received until the next business day.**
3. **I understand that a follow up visit may require from my physician I order to obtain a refill.**
4. **I agree to take all medication exactly as instructed. I am NOT allowed to change the dosage amounts or alter the time schedule of taking the medication without first speaking to my physician.**
5. **Medication will NOT be phoned in after hours or on the weekends.**
6. **Patients may be terminated from the practice within 30 days' notice from non-compliance in the taking of medications.**
7. **Medical Injury Solutions will NOT refill prescriptions that have been lost or misplaced.**
8. **I must keep all appointments as recommended.**
9. **I will not give away, trade or sell medications**
10. **The following are conditions for immediate termination from the practice:**
    a. **Obtaining narcotics from any other physician while under Medical Injury Solutions care.**
    b. **Altering or forging of a prescription. <u>THIS IS A FELONY AND WILL BE REPORTED!</u>**
11. **I am aware that most of the manufacturers of drugs used to treat chronic pain recommend again the operation of heavy equipment, which includes driving a motor vehicle. Please be aware that if you choose to drive you could be charge with a DUI.**
12. **I will not combine any narcotic medication with the consumption of alcohol.**
13. **Only one pharmacy may be used for filling prescriptions.**

_____

My pharmacy's name: ***Location:*** ***Phone:***

I have read, understood and agree to the policies above. I understand that if I do not sign this document, my physician may refuse to prescribe me pain medications.

_____ _____ _____

Please print patient name: ***Patient signature or guardian*** ***Date:***

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Stephen F. Felton, M.D. & Associates

Medical Injury Solutions

DOCTOR'S LIEN

TO: *Attorney*_____
Address: _____
_____
_____

FROM: Medical Injury Solutions
Address: 1445 old McDonough Hwy SE
Conyers, GA 30094_____

Re: Reports and Doctor's Lien for Patient/Client *Name:*_____

I do hereby authorize the above Doctor to furnish you, my attorney, with a full report of examination, diagnosis, treatment, prognosis, ect. of myself, in regard to the accident/injury in which I was involved on_____.

I hereby authorize and direct you, my attorney, to pay directly to Medical Injury Solutions such sums as may be due and owing them for medical service rendered to me to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect Medical Injury Solutions. I hereby further give a lien on my case to Medical Injury Solutions against any and all proceeds of any settlement, judgment or verdict which may be paid to you, my attorney, or myself as the result of the injuries for which I have been treated or injuries in connection therewith.

I fully understand that I am directly and fully responsible to Medical Injury Solutions for all medical bills submitted by them for services rendered to me and that this agreement is made solely for Medical Injury Solutions additional protection and in consideration of his/her awaiting payment. I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee.

Patient's Signature: _____Dated:_____
(OR Parent/Legal Representative/Legal Guardian)

The undersigned being attorney of record for the above patient does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect Medical Injury Solutions.

Attorney's Signature: _____Dated:_____

Attorney: Date, sign and return one copy to Medical Injury Solutions, keep a copy for your records.

Medical Injury Solutions

3rd Party Medical Lien & Assignment

Patient Name: _____ Date of Injury: _____ Claim/Group #: _____

I hereby authorize and direct _____ Insurance Company to pay Dr. Stephen F. Felton, Medical Injury Solutions, such sums as may be due and owing him/her for medical/chiropractic services rendered to me by reason of the accident and to withhold such sums from my settlement, judgment, or verdict as may be necessary to adequately protect and fully compensate said doctor. I further hereby request that payment be made directly to said doctor which would otherwise be paid to myself as result of the treatment charges incurred for injuries in connection therewith. This is a direct assignment of my rights and benefits under this claim.

I fully understand that I am directly and fully responsible to said doctor for all medical bills submitted by him/her for services rendered me and that this agreement is made solely for said doctor's protection and in consideration of his/her awaiting payment. I further understand that such payment is not contingent on any settlement, judgment, or verdict which I may eventually recover.

Please acknowledge your agreement to this request to this request by signing below and returning to the doctor's office below. I have been advised that if you do not wish to cooperate in protecting the doctor's interest, the doctor will not await payment and declare the entire balance due and payable to me.

_____ _____

Date: Patient Signature:

The undersigned insurance company does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgment, or verdict as may be necessary to adequately protect and fully compensate said doctor above and below name and make payment payable directly to said doctor.

_____ _____

Date: Signature of Insurance Company Rep.

_____ _____

Insurance Company Name Print first and last name

PLEASE DATE, SIGN AND RETURN A COPY OF THIS FORM. PLEASE KEEP A COPY FOR YOUR RECORDS.

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Stephen F. Felton, M.D. & Associates