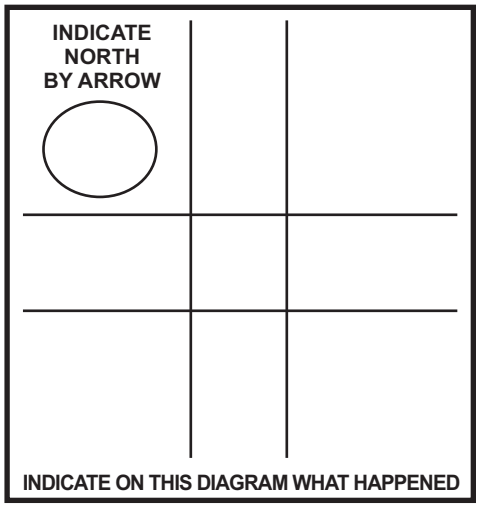
DBMP 00_REV 7/17/14

PATIENT INTAKE - PART 1



1. NAME: _____
2. ADDRESS: _____
CITY, STATE, ZIP: _____
3. PERMANENT ADDRESS **(IF DIFFERENT FROM ABOVE)**
_____
CITY, STATE, ZIP: _____
4. IF PERMANENT ADDRESS IS IN FL, HOW LONG HAVE YOU LIVED IN FL: _____
5. DATE OF BIRTH: _____
6. AGE: _____
7. SEX: _____
8. SOCIAL SECURITY #: _____
9. HOME PHONE: _____
10. WORK PHONE: _____
11. EMAIL ADDRESS:_____
12. DRIVERS LICENCE #: _____
13. MARITAL STATUS: **(CIRCLE ONE) MARRIED SINGLE DIVORCED WIDOWED**
14. OCCUPATION: _____ **(IF UNEMPLOYED, PROCEED TO #15)**
14A. CURRENT EMPLOYER: _____
14B. EMPLOYERS ADDRESS: _____
CITY, STATE, ZIP: _____
15. OTHER OCCUPATION **(IF NO OTHER OCCUPATION, PROCEED TO #15)**: _____
15A. OTHER CURRENT EMPLOYER: _____
15B. EMPLOYER ADDRESS: _____
CITY, STATE, ZIP: _____

ACCIDENT INFORMATION

16. ARE YOU SEEKING TREATMENT DUE TO AN AUTO MOBILE ACCIDENT? **YES NO**
16A. ARE YOU SEEKING TREATMENT DUE TO A WORK RELATED ACCIDENT? **YES NO**
16B. DATE OF ACCIDENT: _____
16C. TIME OF ACCIDENT: _____
16D. PLACE OF ACCIDENT, PROVIDE STREET, CITY OR TOWN: _____
17. WAS THERE POLICE INVOLVEMENT? **(F NO, PROCEED TO #17) YES NO**
17A. WHAT WAS THE NAME OF THE POLICE DEPT. THAT CAME TO THE SCENE? _____
17B. WAS A CASE NUMBER ASSIGNED TO YOUR ACCIDENT? **YES NO**
17C. DO YOU HAVE A COPY OF THE POLICE REPORT? **YES NO**
18. STATE IF YOU WERE THE DRIVER, PASSENGER OR PEDESTRIAN: _____
19. WHAT TYPE OF VEHICLE WERE YOU IN WHEN THE ACCIDENT OCCURRED? **(CIRCLE ONE BELOW)**
CAR CITY BUS TAXI RENTAL CAR PRIVATE BUS PRIVATE VAN LIMO OTHER _____
20. IF RENTAL CAR, DID YOU PURCHASE ADDITIONAL INSURANCE COVERAGE? **YES NO**
20A. IF A CAR RENTAL, DID YOU PURCHASE ADDITIONAL INSURANCE COVERAGE? **YES NO**
20B. IF SO, WHAT TYPE OF COVERAGE DID YOU PURCHASE? _____
21. DO YOU HAVE AN AUTOMOBILE INSURANCE POLICY? **YES NO**
IF YES, WITH WHICH INSURANCE CARRIER? _____ **(IF NO, PROCEED TO #21)**
21A. DO YOU HAVE PIP (PROPERTY DAMAGE INSURANCE)? **YES NO**
21B. DO YOU HAVE MED PAY ON YOUR POLICY? **YES NO**
21C. DO YOU HAVE UNINSURED MOTORIST COVERAGE ON YOUR POLICY? **YES NO**
21D. DO YOU HAVE A CURRENT POLICY THAT CAN BE PRESENTED TO THIS OFFICE? **YES NO**
22. WERE THERE ANY PASSENGER IN THE VEHICLE AT THE TIME OF THIS ACCIDENT? **YES NO**
22A. IF SO, WERE THEY INSURED? **YES NO**
23. WHO OWNS THE VEHICLE INVOLVED IN THE ACCIDENT? _____
24. DO YOU OWN A VEHICLE? **(IF NO, PROCEED TO #24) YES NO**
24A. IF YES, DESCRIBE VEHICLE: _____

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PATIENT INTAKE - PART 2

24B. DOES ANY FAMILY MEMBER HAVE INSURANCE? **YES NO**

24C. ARE YOU LISTED ON THE ABOVE FAMILY MEMBER'S POLICY? **YES NO**

24D. ARE THEY LISTED ON YOUR INSURANCE POLICY? **YES NO**

25. ARE THERE ANY OTHER VEHICLES REGISTERED AT YOUR HOME ADDRESS? **(IF NO, PROCEED TO #26)** **YES NO**

25A. IF SO, ARE THE VEHICLE(S) OPERABLE? **YES NO**

25B. ARE THOSE VEHICLE(S) INSURED? **YES NO**

25C. WHAT IS THE RELATIONSHIP OF THE OWNER OF THOSE VEHICLE(S) TO YOU? _____

25D. WHO IS LISTED ON THEIR POLICY? _____

_____

26. AS A RESULT OF THIS ACCIDENT WERE YOU INJURED **(IF NO, PROCEED TO #29)** **YES NO**

26A. IF YES, DESCRIBE YOUR INJURY? _____

27. DATE WHEN SYMPTOMS FIRST APPEARED: _____

28. WERE YOU TREATED BY A DOCTOR? **(IF NO, PROCEED TO #30)** **YES NO**

29. WERE YOU TREATED IN A HOSPITAL? **(IF NO, PROCEED TO #31)** **YES NO**

29A. IF YES, WERE YOU AN IN PATIENT OR OUT PATIENT? _____

29B. HOSPITAL NAME AND ADDRESS: _____

_____

30. AMOUNT OF MEDICAL BILLS TO DATE: _____

31. WILL YOU HAVE MORE MEDICAL EXPENSES? **YES NO**

32. AT THE TIME OF ACCIDENT, WERE YOU IN THE COURSE OF YOUR EMPLOYMENT? **(IF NO, PROCEED TO #35)** **YES NO**

33. DID YOU LOSE WAGES AS A RESULT OF YOUR INJURY? **(IF NO, PROCEED TO #35)** **YES NO**

34A. IF YES, AMOUNT LOST TO DATE: _____

34B. IF YOU LOST WAGES, DATE DISABILITY FROM WORK BEGAN: _____

34C. DATE YOU RETURNED TO WORK: _____

34D. HAVE YOU RECEIVED OR ARE YOU ELIGIBLE FOR PAYMENT UNDER ANY, WORKERS COMPENSATION OF UNEMPLOYMENT? **YES NO**

35. DO YOU HAVE HEALTH INSURANCE? **YES NO**

35A. IF YES, WHO IS YOUR HEALTH INSURANCE WITH? _____

35B. IS YOUR POLICY AN HMO OR PPO? _____

35C. WHAT IS YOUR POLICY NUMBER? _____

35D. WHAT IS THE EFFECTIVE DATE? _____

35E. DO YOU HAVE HEALTH INSURANCE CARD WITH YOU? **MAKE COPY YES NO**

36. DO YOU OR HAVE YOU DRIVEN A COMPANY VEHICLE? **YES NO**

36A. ARE YOU OR WERE YOU LISTED ON YOUR EMPLOYERS AUTO INSURANCE POLICY? **YES NO**

36B. IS THERE A CO-SIGNER OR OTHER OWNERS FOR THIS VEHICLE? **YES NO**

37. DESCRIBE VEHICLE OWNED BY ANY MEMBER OF YOUR FAMILY LIVING WITH YOU _____

37A. WHO OWNS ABOVE VEHICLE? _____

PAPERWORK COMPLETED BY: _____

WHO WILL BE WITNESSING ALL SIGNATURES: _____

I, THE UNDERSIGNED REPRESENT THAT THE ABOVE IS TRUE AND CORRECT:

_____

PATIENT OR GUARDIAN SIGNATURE: _____ DATE: _____

PRINT NAME: _____