CONFIDENTIAL PATIENT APPLICATION FOR PIP CARE

Welcome to our practice! Please complete all questions. Thank you. [Please Print]

Patient Name:_____ Date:_____/_____/_____ Account #_____

If patient is considered a minor or is under 18 years of age, parent or legal guardian must sign to accept responsibility and complete form.

Responsible party name:_____ Signature:_____

Address:_____ Home Phone:_____

City:_____, State:_____,Zip:_____ Cell Phone:_____

Date of Birth: _____/_____/_____ Age:_____ Gender: Male Female Marital Status: M W D S

Social Security #:_____ Spouse's Name:_____

E-Mail Address:_____ Work Phone:_____

Employed By:_____ Address:_____

Emergency Contact:_____ PH#_____ Cell#_____

Whom may we thank for referring you to our clinic:_____

List your purpose or reason for this appointment:

1._____ for how long?_____

2._____ for how long?_____

3._____ for how long?_____

Does the pain spread? [ ] Yes [ ] No If yes, where?_____
Is there pain when you cough or sneeze? [ ] Yes [ ] No If yes, where?_____
Is there pain when you go from a sit to a stand? [ ] Yes [ ] No If yes, where?_____
Do you have headaches? [ ] Yes [ ] No If yes, check all that apply? [ ] Tension [ ] Throb [ ] Sinus [ ] Migraine

Indicate any function below that aggravate or are aggravated by your condition: (Check all that apply)
[ ] Walking [ ] Step Climbing [ ] Driving [ ] Working [ ] Recreation [ ] Bowel Movements [ ] Vision [ ] Digestion [ ] Breathing
[ ] Sinuses [ ] Hearing [ ] Smelling [ ] Sleeping [ ] If female, Menstrual

AUTO ACCIDENT INFORMATION

Your Auto Ins Co/Address/Phone: _____

_____

Agents Name:_____ Policy#:_____ Clm#_____

Other Car's Auto Ins Co/Address/Phone: _____

_____

Agents Name:_____ Policy#:_____ Clm#_____

Have you retained an attorney? YES NO Name/Phone: _____

Were there any witnesses? YES NO Name(s): _____

Nature of the Accident:

1. Date of Accident: _____ Time of day: _____
2. Where you: ( ) Driver ( ) Passenger ( ) Front seat ( ) Back Seat
3. Number of people in your vehicle? _____Other vehicle? _____
4. What direction were you headed? ( ) North ( ) East ( ) South ( ) West on (name of street)

   _____
5. What direction was the other vehicle headed? ( ) North ( ) East ( ) South ( ) West on (name of street)

   _____
6. Where you struck from ( ) Behind ( ) Front ( ) Left Side ( ) Right Side
7. Were you knocked unconscious? ( ) YES ( ) NO
8. Were the police notified? ( ) YES ( ) NO
9. In your own words, please describe the accident:

   _____

   _____

   _____

   _____
10. Did you have any physical complaints BEFORE THE ACCIDENT ( ) YES ( ) NO if yes please describe:

    _____

    _____

    _____
11. Please describe how you felt:
    a. DURING the accident: _____
    b. IMMEDIATELY AFTER the accident: _____
    c. LATER THAT DAY: _____
    d. THE NEXT DAY: _____
12. What are your PRESENT complaints and symptoms? _____

    Describe: _____
13. Do you have any previous illnesses which related to this case? ( ) YES ( ) NO if yes please describe:

    _____
14. Have you ever been involved in an accident before? ( ) YES ( ) NO if yes, please describe, including date(s) and type(s) of accidents as well as injury(ies) received.
15. Where were you taken after the accident? _____
16. Have you been treated by another doctor since the accident? ( ) YES ( ) NO if yes, please list doctor's

name and address: _____

what type of treatment did you receive? _____

_____

17. Since this injury occurred, are your symptoms: ( ) improving ( ) Getting worse ( ) Same

18. CIRCLE THE SYMPTOMS YOU HAVE NOTICED SINCE THE ACCIDENT:

Headache	Neck Pain	Neck Stiff	Fatigue	Back pain	Nervousness
Lights bother Eyes	Loss of Balance	Loss of Smell	Head seems Heavy	Sleeping Problems	Tingling in Arms
Tingling in Legs	Numb Fingers	Numb Toes	Shortness of Breath	Loss of Smell	Loss of Taste
Buzzing Ears	Ears Ringing	Face Flushed	Depression	Diarrhea	Fainting
Cold Feet	Cold Hands	Tension	Chest Pain	Irritability	Constipation
Fever	Dizziness	Cold Sweats	Upset Stomach		

Symptoms other than listed above: _____

19. Have you lost time from work as a result of this accident? ( ) YES ( ) NO if yes please complete these:

    A. Last day worked: _____

    B. Type of employment: _____

    C. Present Salary: _____

    D. Are you being compensated for time lost at work? ( ) YES ( ) NO

20. Do you notice any activity restrictions as a result of this injury? ( ) YES ( ) NO if yes, please describe in detail: _____

_____

_____

21. Other pertinent information: _____

_____

_____

22. Please draw (the best you can) how the accident happened:

How often do you drink alcoholic beverages? _____

Do you smoke [ ] Yes [ ] No if so how much: _____

Do you exercise [ ] Yes [ ] No if so how often: _____

Do you have any Allergies? (Specify): _____

Medication List

Medication	Vitamins	Non-Rx Strength	Rx Strength	Date Started	Date Ended	Prescribed by Whom

Please Identify all facilities/providers you have seen for these conditions and those you currently are seeing. If an, for your presenting problem(s)

Problem List

Dr Name/Facility	Problem	Type of Treatment Received	From Whom and When

Confidential: Please make the doctor aware if you are HIV positive, or if you have any other communicable diseases, i.e., TB, Hepatitis.

Medical Information Release Information (HIPAA Release Form)

[ ] I authorize Dr. Hannouche to provide treatment for my condition(s) found through examination and/or x-rays related to vertebral subluxation.

[ ] I authorize Hannouche family Chiropractic to contact me via [ ] my home [ ] my work [ ] my cell number: _____

If unable to reach me:

[ ] you may leave a detailed message

[ ] please leave a message asking me to return your call

[ ] _____

The best time to reach me is [ ] Day time between the hours of _____ and _____

[ ] I authorize the release of information including the diagnosis, records and examination results rendered to me and claims information to me my insurance company if requested as well as any per son listed below:

[ ] Spouse _____

[ ] Child(ren) _____

[ ] Other _____

[ ] Release no information without my [ ] written [ ] verbal consent.

Signed: _____ Date: _____/_____/_____

Witness: _____ Date: _____/_____/_____

MEDICAL REPORTS AND DOCTOR'S LIEN

I do hereby authorize Hannouche Family Chiropractic Clinic to furnish you, my attorney, with a full report of his examination, diagnosis, treatment, prognosis, etc., of myself in regard to the accident in which I was recently involved.

I hereby authorize and direct you, my attorney, to pay directly to Dr. Hannouche (doctor) such sums as may be due and owing to him for medical service rendered to me both by reason of this accident and by reason of any other bills that are due his office and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect said doctor, and hereby further give a lien on my case to said doctor against any and all proceeds of my 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 said doctor for all medical bills submitted by him for service rendered me and that this agreement is made solely for said doctor's additional protection and in consideration of the 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.

Please acknowledge this letter by signing below and returning to the doctor's office. I have been advised that if my attorney does not wish to cooperate in protecting the doctor's interest, the doctor will not await payment but will require me to make payments on a current basis.

_____ _____

Patient Signature Dated

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 said doctor named above.

_____ _____

Attorney's Signature Dated

Please date, sign and return one copy to doctor's office. Also keep one copy for your records.

Hannouche Family Chiropractic Clinic
1203-A Boiling Springs Road
Spartanburg, SC 29303
Phone: 864-583-5649 Fax: 864-583-5509

NOTICE TO INSURANCE COMPANY OF ASSIGNMENT

TO: _____ **DATE:** _____

_____

_____

_____

You are hereby instructed to pay directly to the doctor at this office all professional services rendered to you by this office. This instruction to you is an assignment of my rights under medical coverage to the extent of this bill.

Any sum of money paid under this assignment shall be credited to my account and I shall be personally liable for any unpaid balance to the doctor. Please forward payments to the address listed above.
Tax ID: 57-0700947 Facility NPI: 1780747808

Patient Name/ Address: _____

Policy #: _____ Claim #: _____

Patient Signature: _____

Acknowledgement of Insurance Company

This insurance company hereby acknowledges receipt of the above instruction and agrees to mail payment of medical coverage benefits of the policy directly to the office of and to the order of the doctor only

_____ _____

Authorized Signature Date