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 age 18 parent or legal guardian must sign to accept responsibility and complete form: Responsible Party Name: _____ *Signature* _____

Address: _____ Home Phone_____

City: _____ State: _____ Zip: _____ Cell: _____

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

Social Security # _____ - _____ - _____ Spouse's Name: _____

Email: _____ Work Ph: _____

Employer: _____ Employer Address: _____

Emergency Contact: _____ Ph: _____ Cell: _____

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

List your reason for this appointment:

1. _____How Long? _____
2. _____ How Long? _____
3. _____ How Long? _____

Does the pain spread (radiate)? [ ] 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 sit to 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 aggravates, or is aggravated by, your condition: (check all that apply)

[ ] Walking [ ] Step Climbing [ ] Driving [ ] Working [ ] Recreation [ ] Bowel Movements

[ ] Sinuses[ ] Digestion [ ] Breathing [ ] Hearing [ ] Vision [ ] Smelling [ ] Sleeping [ ] Menstrual

AUTO ACCIDENT DETAILS

Your Auto Ins Co. / Address / Ph: _____

Agent Name: _____ Policy# _____ Claim# _____

Other Driver's Auto Ins Co. / Address / Ph: _____

Agent Name: _____ Policy# _____ Claim# _____

Have you retained an attorney? [ ] Yes [ ] No Name / Ph: _____

Were there any witnesses? [ ] Yes [ ] No Names: _____

_____

NATURE OF THE ACCIDENT

Date of Accident _____ Time of Day: _____

Were you: [ ] Driver [ ] Passenger [ ] Front Seat [ ] Back Seat

Number of people in your vehicle? _____ In other vehicle? _____

Direction headed? [ ] North [ ] South [ ] East [ ] West On (name of street) _____

Other vehicle? [ ] North [ ] South [ ] East [ ] West On (name of street) _____

Were you struck from [ ] Behind [ ] Front [ ] Left Side [ ] Right Side

Were you knocked unconscious? [ ] Yes [ ] No Were the police notified? [ ] Yes [ ] No

Please describe the accident in your own words: _____

_____

_____

Do you have any physical complaints from BEFORE THE ACCIDENT? [ ] Yes [ ] No

Please describe how you felt:

- DURING the accident: _____
- IMMEDIATELY AFTER the accident: _____
- LATER that day: _____
- The NEXT : _____

What are your *present* complaints and symptoms?_____

_____

Do you have any previous illnesses which relate to this case? [ ] Yes [ ] No If yes, please describe:

_____

Have you ever been involved in an accident before? [ ] Yes [ ] No If yes, please describe. Include dates, types of accidents, and any injuries received: _____

_____

_____

Which health provider were you taken to after the accident?_____

Have you been treated by another doctor since the accident? [ ] Yes [ ] No If yes please provide doctor's name and address: _____

What type of treatment did this doctor provide? _____

Since this injury occurred, are your symptoms: [ ] Improving [ ] Getting worse [ ] Staying the same

Check any symptoms you have noticed since the accident occurred:

Head / Neck / Back	Chest / Digestive	Nervous System	Sensory	Circulatory
Headache	Shortness of Breath	Tingling in Arms	Eyes Sensitive to Light	Cold Feet
Head Feels Heavy	Upset Stomach	Tingling in Legs	Loss of Smell	Cold Hands
Neck Pain	Diarrhea	Numb Fingers	Loss of Taste	Face Becomes Flushed
Neck Stiffness	Constipation	Numb Toes	Buzzing in Ears	Cold Sweats
Dizziness	Heartburn	Anxiety	Ringing in Ears	**Other:**
Fainting		Depression	Sleep Problems	
Loss of Balance		Tension	Fatigue	
Back Pain		Irritability		

Have you lost time from work because of this accident? [ ] Yes [ ] No If yes, please complete the following:

- Type of employment_____
- Last day worked_____
- Present Salary_____
- Are you being compensated for time lost at work? [ ] Yes [ ] No

Do you notice any activity restrictions because of this injury? [ ] Yes [ ] No If yes, please describe in detail:

_____

_____

_____

Any other pertinent information? _____

_____

Please draw, as best you can, how the accident happened:

How often do you drink alcoholic beverages? _____

Do you exercise? [ ] Yes [ ] No If yes, how often? _____

Do you have allergies? [ ] Yes [ ] No If yes, please specify: _____

Do you smoke? [ ] Yes [ ] No [ ] On occasion

MEDICATION LIST

Medication	Vitamin/Supplement	Rx Strength	Non-Rx Strength	Start Date	End Date	Prescribing Professional/Dr.

If you need more space to list you may write on the back of this form.

PROVIDER LIST

Provider / Facility	Problem	Type of Treatment Received	Dates of Treatment

Confidential: Please make doctor aware if:
You are HIV+, or have any other communicable diseases, i.e. TB, Hepatitis, et al.

MEDICAL INFORMATION RELEASE INFORMATION [HIPAA RELEASE FORM]

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

[ ] I authorize Hannouche Family Chiropractic Clinic to contact me via: [ ] Home Ph [ ] Work Ph [ ] Cell

If unable to reach me: [ ] Leave a detailed message [ ] Leave message for return call [ ] Other _____

Best time to reach me: [ ] Daytime: _____ [ ] Evening: _____

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

[ ] Spouse / Significant Other: _____

[ ] Child/Children: _____

[ ] Other: _____

[ ] Release no information without my [ ] written consent [ ] 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 regarding the accident in which I was recently involved.

I hereby authorize and direct you, my attorney, to pay directly to Dr. Nicholas 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, judgement, 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 to 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, judgement or verdict by which I may eventually recover said fee.

Please acknowledge this letter by signing below and returning it 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 Signature Dated

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

Hannouche Family Chiropractic Clinic
1205 Boiling Springs Road
Spartanburg, SC 29303
(864) 583-5649
Hannouchefamilychiropractic.com

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