



Bentin Chiropractic

Wellness Center

(561) 736-WELL (9355)
(561) 736-6661 (Fax)

Personal Injury Questionnaire

Patient Information

First Name _____ M.I. _____ Last _____
Home Address _____ Apt # _____
City _____ State _____ Zip _____
Home Phone _____ Cell Phone _____
Work Phone _____ E-mail Address _____
Birthdate: ____/____/____ Gender: ☐ M ☐ F Age: _____
Social Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated
Social Security Number _____
How did you hear about us? ☐ Coupon/Gift Cert. ☐ Internet ☐ Banner ☐ Referred By: _____
Employer Name _____ Occupation _____
Employer Address _____

Who to Contact in Case of Emergency:

Name _____ Relation to Patient _____
Home Phone _____ Work phone _____ Ext _____

Insurance information

- Driver of Vehicle in which you were injured: _____
Insurance Company: _____ Policy# _____
Address: _____
- Does their policy include Personal Injury Protection (PIP): ☐ Yes ☐ No
- Accident Claim #: _____ Insurance Adjuster Name: _____
Adjuster Phone Number: _____
Address to send billing information: _____

Accident Information

- Please explain **IN DETAIL** how your accident happened: _____

- Time and Date of Accident: _____
- Where did the accident occur? (Intersection or Highway, etc.) _____
- Were the police notified of the accident? ☐ Yes ☐ No
- You were heading: ☐ North ☐ South ☐ West ☐ East
- Other Vehicle was headed: ☐ North ☐ South ☐ West ☐ East
- Were you struck from: ☐ Behind ☐ Front ☐ Drivers Side ☐ Passenger Side
- What were the circumstances (were you stopped, moving, turning, etc.): _____
- Was any one else in your car at the time of the accident? ☐ Yes ☐ No Were they injured? ☐ Yes ☐ No
- You were the: ☐ Driver ☐ Passenger ☐ Front Seat ☐ Back Seat ☐ Using Seat Belts
- Head rest in proper position (top of head rest at center of back of head)? ☐ Yes ☐ No

- Did you hit your head or knees: ☐ Yes ☐ No Seat came loose? ☐ Yes ☐ No

Patient Name _____ Date _____

- What were your immediate symptoms: ☐ Dizzy ☐ Unconscious, how long: _____
☐ Pain, where: _____ ☐ Other: _____
- Primary Complaint Now: _____
- Pains are: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Aching ☐ Numbness ☐ Shooting
☐ Burning ☐ Tingling ☐ Spasm ☐ Stiffness ☐ Swelling ☐ Other _____
- Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown
- Is the pain: ☐ Occasional (0-25%) ☐ Intermittent (25-50%) ☐ Frequent (50-75%) ☐ Constant (75-100%)
- Does the pain radiate? ☐ Yes ☐ No, if yes, Where does it radiate? _____
- Activities or movements that are difficult to perform:
☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down ☐ Other _____
- What treatment have you already received for this condition? ☐ Medications ☐ Physical Therapy
☐ Surgery ☐ Chiropractic ☐ None ☐ Other _____
- Activities or movements that improve the condition: _____
- Second Complaint _____ When did it start? _____
- Did you go to the Doctor/Hospital after the accident? ☐ Yes ☐ No If yes, what treatment was given: _____
- Was any other Doctor consulted after your accident? ☐ Yes ☐ No
If yes, Doctor's name: _____ ☐ D.C. ☐ M.D. ☐ D.O. ☐ P.A.
- How many times were you seen? _____ Diagnosis: _____
- Have you had any complaints in involved area before? ☐ Yes ☐ No
If yes, explain: _____
- Has anyone recommended surgery? ☐ Yes ☐ No
- How do you feel in a.m.? ☐ Better ☐ Worse ☐ No difference
- How do you feel in p.m.? ☐ Better ☐ Worse ☐ No difference
- Is condition getting worse? ☐ Yes ☐ No ☐ Constant ☐ Comes and goes
- Have you been unable to work since the accident? ☐ Yes ☐ No
Dates unable to work: _____
- Are you partially disabled? ☐ Yes ☐ No if yes, explain: _____
- What can you **NOT** do now that you could do before?: _____
- Before this injury, were you able to work on an equal basis with others your age? ☐ Yes ☐ No
- Medications you are taking now due to the Accident: ☐ Pain Killers ☐ Anti-Inflammatory ☐ Muscle Relaxers
☐ Others: _____

Check symptoms you have noticed SINCE THE ACCIDENT:

- | | | | | |
|---|---|---|---|---|
| <input type="checkbox"/> Headache | <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Neck Stiffness | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Tension |
| <input type="checkbox"/> Irritability | <input type="checkbox"/> Loss of Taste | <input type="checkbox"/> Loss of Smell | <input type="checkbox"/> Loss of Memory | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Neuritis | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Fainting | <input type="checkbox"/> Chest pain | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Depression | <input type="checkbox"/> Eye strain | <input type="checkbox"/> Nausea, vomiting | <input type="checkbox"/> Face flushed |
| <input type="checkbox"/> Palpitation | <input type="checkbox"/> Tremors | <input type="checkbox"/> Pallor | <input type="checkbox"/> Sinus trouble | <input type="checkbox"/> Mental Dullness |
| <input type="checkbox"/> Extreme Nervousness | <input type="checkbox"/> Extreme Fatigue | <input type="checkbox"/> Pain Behind Eyes | <input type="checkbox"/> Double Vision | <input type="checkbox"/> Digestive Disorder |
| <input type="checkbox"/> Equilibrium Disorder | <input type="checkbox"/> Head seems too heavy | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Excessive perspiration | <input type="checkbox"/> Upper back- pain, stiff |
| <input type="checkbox"/> Mid-back- pain, stiff | <input type="checkbox"/> Feet cold; Hands cold | <input type="checkbox"/> Restricted Neck Motion | <input type="checkbox"/> Buzzing/Ringing Ears | <input type="checkbox"/> Eyes Sensitive to light |
| <input type="checkbox"/> Head/Shoulders Feel tired/heavy | <input type="checkbox"/> Pins and Needles in arms/legs | <input type="checkbox"/> Numbness in fingers/arms/legs | <input type="checkbox"/> Difficulty in prolonged riding in car | <input type="checkbox"/> Difficulty in excessive lifting |
| <input type="checkbox"/> Neck/Low Back pain/stiffness upon rising | <input type="checkbox"/> Pain radiating into right/left/both arms/leg | <input type="checkbox"/> Difficulty in excessive standing/walking/bending | <input type="checkbox"/> Difficulty in excessive turning/twisting | <input type="checkbox"/> Difficulty in rising to walk after sitting |

Patient Name _____ Date _____

Health Information

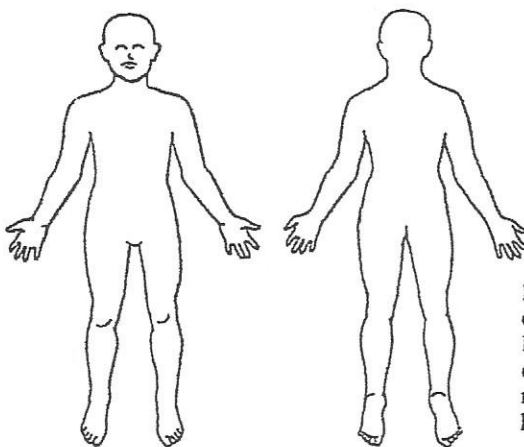
- Date of last Physical Examination: _____ Have you had previous Chiropractic Care?: ☐ Yes ☐ No
- Doctor's Name: _____ When? _____
- Why? _____ Were x-rays taken? ☐ Yes ☐ No
- Are you Pregnant? ☐ YES ☐ NO Nursing? ☐ YES ☐ NO
- Who is your current medical doctor? _____
- Please list ALL Surgeries you've had: _____
- Allergies: _____
- Please list ALL Medications you are taking? _____
- Are you Pregnant? ☐ YES ☐ NO Nursing? ☐ YES ☐ NO Taking Birth Control? ☐ YES ☐ NO
- Do you Smoke? ☐ YES ☐ NO if Yes, how much? _____ packs/day
- Do you Drink Alcohol? ☐ YES ☐ NO How Much? _____ glass/ (circle one) Day Week Month Year
- How much do you exercise? _____ minutes/ (circle one) Day Week Month Year

Mark Any Condition you have either had in the Past or Currently Have:

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Depression | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Psychiatric Care |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Measles | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Allergy Shots | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Miscarriage | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Anorexia | <input type="checkbox"/> Fractures | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Suicide Attempt |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Goiter | <input type="checkbox"/> Mumps | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Breast Lump | <input type="checkbox"/> Gout | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Parkinson's Disease | <input type="checkbox"/> Tumors, Growths |
| <input type="checkbox"/> Bulimia | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Pinched Nerve | <input type="checkbox"/> Typhoid Fever |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hernia | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Herniated Disc | <input type="checkbox"/> Polio | <input type="checkbox"/> Vaginal Infections |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Herpes | <input type="checkbox"/> Psychiatric Problems | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Prostate Problems | <input type="checkbox"/> Other _____ |

Pain Diagram

Area of Most Pain										
Better	Pain at Present:	Worse								
0	1	2	3	4	5	6	7	8	9	10
Pain at its Worst:										
0	1	2	3	4	5	6	7	8	9	10
Pain at its Best:										
0	1	2	3	4	5	6	7	8	9	10
Area 2 nd Most Pain										
Better	Pain at Present:	Worse								
0	1	2	3	4	5	6	7	8	9	10
Pain at its Worst:										
0	1	2	3	4	5	6	7	8	9	10
Pain at its Best:										
0	1	2	3	4	5	6	7	8	9	10



KEY	
Stabbing	xxx
Pins & Needles	ooo
Numbness	= =
Aching	+++
Burning	////

Please indicate where you are experiencing pain by drawing the letter abbreviations on the diagrams that most accurately reflect the type of discomfort you have been experiencing.



BENTIN CHIROPRACTIC

7545 W. Boynton Beach Blvd., Suite 102
Boynton Beach, FL 33437
Telephone: (561) 736-9355

RELEASE OF MEDICAL RECORDS:

I am requesting that my medical records be released to:

Bentin Chiropractic Wellness Center
7545 Boynton Beach Blvd. Suite 102
Boynton Beach, Florida 33447
Phone: 561-736-9355 Fax: 561-736-6661

Patient Signature: _____

Date: _____



Consent For Use and Disclosure of Health Information

Section A: Patient Giving Consent

Name: _____

Address: _____

Telephone: _____ Social Security: _____

Section B: To the Patient – Please read the following statements carefully.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of our protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice at any time by contacting:

Bentin Chiropractic Wellness Center

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and healthcare operations.

Signature: _____ Date: _____

ACKNOWLEDGMENTS

1. *I instruct the chiropractor to deliver the care that, in his or her professional judgment can best help me in the restoration of my health, I understand that the care offered at Bentin Chiropractic is based on evidence and designed to reduce or correct vertebral subluxation. Chiropractic is a separate and distinct health art form from medicine and does not proclaim to cure any named disease or entity.*
2. *I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties.*
3. *I grant permission to be called to confirm or reschedule an appointment and to be sent occasion cards, letters, email or health information as an extension of my care in the office.*

INSURANCE POLICY/FINANCIAL POLICY AND RELEASE OF AUTHORIZATION

Insurance is a contract between you and your insurance company. As a courtesy to you, we will verify and file claims to your PRIMARY insurance only. Verification is not a guarantee of benefits or payment. Your insurance company will make the final determination of eligibility and subsequent payment.

I authorize the release of any information necessary to process my insurance claims. I authorize and request payment of insurance benefits be paid directly to Bentin Chiropractic. I agree that this authorization will cover all services rendered until I revoke the authorization. I understand that I am financially responsible for any charge not covered by this assignment.

Copayments are due at the time of service unless other written arrangements have been approved. If unpaid balances are more than 60 days delinquent, you may be referred to a collection agency.

Returned Checks-There will be a \$12 fee for any returned checks.

Patient or Responsible Party Signature _____

Date: _____

AUTHORIZATION TO PAY PHYSICIAN

I hereby authorize the _____ insurance company to pay by check and made out and mailed directly to:

Bentin Chiropractic Wellness Center
7545 Boynton Beach Blvd. #102
Boynton Beach, Florida 33437

The medical expense benefits allowable and otherwise payable to me under my current insurance policy, as payment toward the total charges for professional services rendered. This payment will not exceed my indebtedness to the above mentioned assignee and I agree to pay, in a current manner, any balance of said professional service charge over and above this insurance payment.

If my current policy prohibits direct payment to doctor, then I hereby authorize you to make a check to me and mail it as follows:

c/o Bentin Chiropractic Wellness Center
7545 Boynton Beach Blvd. #102
Boynton Beach, Florida 33437

THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY

A photocopy of this assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster or attorney involved in this case.

Date _____

Signature of policy holder _____

Signature of Claimant _____

Witness _____



OFFICE OF INSURANCE REGULATION
Bureau of Property & Casualty Forms and Rates

Standard Disclosure and Acknowledgement Form
Personal Injury Protection - Initial Treatment or Service Provided

The undersigned insured person (or guardian of such person) affirms:

1. The services or treatment set forth below were **actually rendered**. This means that those services have already been provided.

Spinal Manipulation, Hot Packs, Ultrasound, Electrical Mus. Stim
Trigger point Therapy, Cold Laser, Manual Therapy, Therapeutic

2. Exercises, Range of Motion, Muscle Testing
I have the right and the **duty to confirm** that the services have already been provided.

3. I was **not solicited** by any person to seek any services from the medical provider of the services described above.

4. The medical provider has **explained** the services to me for which payment is being claimed.

5. If I notify the insurer in writing of a billing error, I may be entitled to a portion of any reduction in the amounts paid by my motor vehicle insurer. If entitled, my share would be at least 20% of the amount of the reduction, up to \$500.

Insured Person (patient receiving treatment or services) or Guardian of Insured Person:

Name (PRINT or TYPE)

Signature

Date

The undersigned licensed medical professional or medical director, if applicable, affirms the statement numbered 1 above and also:

- A. I have **not solicited** or caused the insured person, who was involved in a motor vehicle accident, to be solicited to make a claim for Personal Injury Protection benefits.
- B. The treatment or services rendered were explained to the insured person, or his or her guardian, **sufficiently** for that person to sign this form with informed consent.
- C. The accompanying statement or bill is **properly completed** in all material provisions and all relevant information has been provided therein. This means that each request for information has been responded to **truthfully, accurately**, and in a **substantially complete** manner.
- D. The coding of procedures on the accompanying statement or bill is proper. This means that **no service has been upcoded, unbundled**, or constitutes an invalid or **not medically necessary diagnostic test** as defined by Section 627.732 (15) and (16), Florida Statutes or Section 627.736(5)(b)6, Florida Statutes.

Licensed Medical Professional Rendering Treatment/Services or Medical Director, if applicable (Signature by his/ her own hand):

Name (PRINT or TYPE)

Signature

Date

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of Claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree per Section 817.234(1)(b), Florida Statutes.

Note: The **original** of this form must be furnished to the insurer pursuant to Section 627.736(4)(b), Florida Statutes and may **not** be electronically furnished. Failure to furnish this form may result in non-payment of the claim.