Complete Injury Care

SLIP AND FALL

PATIENT FORMS

(570) 622-0809
200 E. ARCH ST. #102
POTTSVILLE, PA 17901

Complete Injury Care

For Office Use Only:				
Patient Number__________________		PI____	Attorney______________________________	
Cash______	WC______	GI______	Med Pay_______	Date of Accident________________

PATIENT INFORMATION   Today's Date:_________________

Name:____
(First)   (Middle)   (Last)

Address:____

City:______________________________   State:_____________________   Zip:___________

Social Security #:____/_____/____   Driver License #_________________ Sex: ( ) Male ( ) Female

Birth date:______/_______/________   Age:_________   Dominant Hand: ( ) Right ( ) Left

Marital Status: ( ) Single   ( ) Married   ( ) Widowed   ( ) Separated   ( ) Divorced

Minor: ( ) Yes   ( ) No

Home #:____________________Cell #:_____________________   Work #:_____________________

Email Address:____

Employer / School:______________________________   Occupation:_____________________________

Employer Address:____

City:______________________________   State:_____________________   Zip:___________

Emergency Contact Person:____________________________   Relationship:_______________________

Home #:____________________   Cell #:_____________________

Whom may we thank for referring you to us?____

Allergies:____

Past Medical History:	Past Surgical History:	Family History:
______________________	______________________	______________________
______________________	______________________	______________________

Attorney Information (If applicable):

Attorney's Name:_______________________________ Case Manager's Name:____________________

Attorney's Address:____ Phone #:_________________

City:____________________________ State:_________________________ Zip:_______________

Medical Provider Information (If applicable):

Primary Care Physician's Name:____

Address:____ Phone #:_____________________

City:__________________________ State:_______________________ Zip:_______________

Automobile Insurance Information (If applicable):

Your Car Insurance:____________________________________ Phone #________________________

Policy #:______________________________________ Claim #:________________________________

Do You Have Medical Payment Coverage On Your Policy: ( ) Yes ( ) No Amount $:______________

Other Driver's Insurance_________________________________ Phone #________________________

Policy #:____ Claim #:______________________________

Health Insurance Information (If applicable):

Insurance Company:___________________________________ Phone #__________________________

Address:____

Name of Insured:_________________________________ Relationship:__________________________

ID#:_____________________ Group #:_____________________ Employer:_____________________

Social Security #:_______/______/_______ Date of Birth:___________________

Worker's Compensation Information (If applicable):

Insurance Company:______________________________________ Phone #______________________

Billing Address:____

Employer:_______________________________________ Phone #:________________________

Case Manager:_____________________________________ Claim #:__________________________

Complete Injury Care

Informed Consent

Dear____,

Every type of healthcare procedure and/or treatment is associated with some degree of risk. This includes chiropractic care. We want you to be informed about potential problems with chiropractic healthcare before consenting to treatment.

Chiropractic adjustments involve the moving of joints in the body with the use of the doctor's hand, use of a machine, use of a mechanical table, or use of a hand held instrument. Frequently, adjustments create a "pop" or "click" sound / sensation in the area being treated.

In this office, we use trained staff to assist the doctor with portions of your consultation, examination, x-ray taking, physical therapy application, and other treatment modalities. If you only want to be seen by the chiropractor in this clinic, please inform the staff immediately and that request will be honored.

NATURE AND PURPOSE OF CHIROPRACTIC PROCEDURES

The practice of chiropractic includes many standard examination and testing procedures. These include: Physical examinations, orthopedic and neurological testing, palpation, specialized instrumentation's, laboratory tests, radiology examinations, physical therapy, and rehabilitative procedures.

There are a number of different adjusting techniques, some utilizing specially designed equipment. Adjustments are usually performed by hand but may be performed by hand-guided instruments. A chiropractic adjustment is the application of a quick precise movement over a very short distance to a specific segmental contact point of vertebra.

If during the course of care we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another health care provider.

All chiropractic physicians providing care at Complete Injury Care are licensed by the Chiropractic Physician's Board of Pennsylvania in accordance with state laws.

POSSIBLE RISKS ASSOCIATED WITH CHIROPRACTIC PROCEDURES

Not only should you understand the benefits of chiropractic care in restoring and maintaining good health, but also you should be aware of the existence of some inherent risks and limitations. These are seldom enough to contraindicate care, but should be considered in making the decision to receive chiropractic care. All health care procedures, including those used in varying degrees, have some risks associated with them. Risks associated with some chiropractic adjusting procedures may include:

- Stroke
- Verterbral disc herniation
- Soft tissue injury
- Rib fractures
- Physical therapy burns
- Soreness

INITIAL__________

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

Upon request Complete Injury Care will provide each patient with Privacy Practices of Complete Injury Care. This document describes the Practice's policies and procedures regarding the use and disclosure of any of my Protected Health Information created, received or maintained by the practice.

CONSENT OF TREATMENT / INFORMATION

I consent to Complete Injury Care ("the Practice's") use and disclosure of my Protected Health Information for the purposes of providing treatment to me, for purposes relating to the payment of services rendered to me and for the Practices general healthcare operations purposes. This information may be furnished to your insurance carrier, any third party insurance carrier, any physician you may be referred to and your primary care physician.

For purposes of this Consent, "Protected Health Information" means any information, including my demographic information, created or received by the Practice, which relates to my past, present, or future physical or mental health or condition; the provisions of health care to me; or the past, present, or future payment for the provision of health care services to me; and that either identifies me or from which there is a reasonable basis to believe the information can be used to identify me.

This authorization shall be considered as continuing unless you advise Complete Injury Care in writing. I understand I have the right to request a restriction on the use and disclosure of my Protected Health Information for the purposes of treatment, payment or healthcare operations of the Practice, but the Practice is not required to agree to these restrictions. However, if the Practice agrees to a restriction that I request, the restriction is binding on the practice.

By signing this form I acknowledge that I have received, reviewed, and understand the following documents.

______________________________ ______________________

(PRINTED NAME) **(DATE)**

____

(SIGNATURE)

Dr. Eric J. Homa, DC, CICE

200 E. Arch St. #102
Pottsville, PA 17901

Complete Injury Care

SLIP & FALL INJURY FORM

Name: ____

Today's Date:__________

Date of Injury: _________Time of Injury: ___________________________am/pm

Where were you when this happened?

____

Surface conditions at the time of your injury: WET, DRY, ICY, OTHER - CIRCLE ONE

Did security or a staff member arrive at the scene of your injury? YES NO -CIRCLE ONE

Is there a report? YES NO -CIRCLE ONE Did you request the report? YES NO -CIRLCE ONE

Did you go to the hospital? YES NO -CIRLCE ONE

If yes, what Hospital?

____

How did you get to the hospital/ Who transported you? AMBULANCE, SELF, SPOUSE, FRIEND

What parts of your body were x-rayed at the hospital?

____

What did the hospital do for your injuries?

____

How long did you stay at the hospital?

____

Did you sustain cuts or bleed as a result of this injury?

____

Did you sustain bruises as a result of this injury?

____

Did you lose consciousness (black out) upon impact? Circle One- YES NO   How long:___________________________

Did you experience a flash of light or explosion in your head? Circle One- YES NO

Did you experience one or more of the following from this injury? Circle all that apply

CONFUSED, DISORIENTED, LIGHTHEADED, DIZZY, NAUSEATED, BLURRED VISION, RING/BUZZ IN EARS

Do you still have any of the above symptoms and if so circle which ones? Circle all that apply

CONFUSED, DISORIENTED, LIGHTHEADED, DIZZY, NAUSEATED, BLURRED VISION, RING/BUZZ IN EARS

Are you currently experiencing any of the following as a result of this injury: Circle all that apply

DIFFICULT CONCENTRATING, RESTLESSNESS, SLEEPLESSNESS, REDUCED TOLERANCE TO HEAT,

DIFFICULTY WITH MEMORY, CHILLS, REDUCED TOLERANCE TO ALCOHOL, IRRITABLE, FORGETFULNESS

Did you any of the following body parts get injured? (Describe briefly)

Head ____

Chest ____

Right/Left Shoulder ____

Right/Left Arm ____

Right/Left hip ____

Right/Left Leg ____

Right/Left knee____

Other ____

Were you off work as a result of your injuries? Yes No -Circle One   If yes, from ______ to______.

What type of physical effort is required in your line of work?

____

Does your work aggravate your pain? Yes, No, Somewhat - Circle One

Please describe, to the best of your knowledge, what happened during this injury:

____

____

____

Thank you for taking the time to fill out this form.

Patient Signature: _________________________ Date: ________________

Complete Injury Care

FUNCTIONAL LOSS

DUTIES UNDER DURESS / LOSS OF ENJOYMENT OF LIFE

PATIENT NAME:____ DATE:______________________

This checklist is to help us understand how much discomfort, pain, and/or difficulty you are having while doing certain activities. Please check **ONE COLUMN** for each activity. If a particular activity does not apply to you or you have not yet tried that activity check "not applicable."

ACTIVITY	NOT APPLICABLE	NO DISCOMFORT/ DIFFICULTY	MINIMAL DISCOMFORT/ DIFFICULTY	MODERATE DISCOMFORT/ DIFFICULTY	MAJOR DISCOMFORT/ DIFFICULTY	CAN'T DO THIS ACTIVITY BECAUSE OF DISCOMFORT/ DIFFICULTY
SITTING						
STANDING						
BENDING						
LIFTING						
WALKING						
LYING DOWN						
SLEEPING						
DRIVING						
WORKING						
HOUSEWORK						
PERSONAL CARE / DRESSING						
CARING FOR CHILDREN						
USING THE COMPUTER						
EXERCISING / PLAYING SPORTS						
WATCHING TV						
OTHER: ____________						

PATIENT SIGNATURE:____ DATE:____________________