

Patient Information

Please provide all information requested. If you have any questions or need help, please call the office (703-578-1900) or see one of the staff when you arrive for your first appointment.

(Please print clearly)

Last Name _____ First Name _____ MI _____ Date _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Social Security # _____ - _____ - _____ Birth Date ____/____/____ Age _____

Driver's License # _____ Check One: () Male () Female

Occupation _____ Email _____

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

Employer

() Not working, or Company _____

Address _____

City _____ State _____ Zip _____ Work Phone _____

Spouse

Last Name _____ First Name _____

() Not working, or Company _____

Address _____

City _____ State _____ Zip _____ Work Phone _____

Minors (under 18)

Parent's Name _____ Signature Authorizing Care _____

Nearest Relative not Living with You

Name _____ Phone _____

Address _____

City _____ State _____ Zip _____ Relationship _____

(Patient Information Continued)

Patient's Name _____

All patients complete section 1.

1. Medical Insurance Information

Check here if no insurance ()

Insurance Company Name _____

Group No./ID No. _____ Address _____

City _____ State _____ Zip _____

If subscriber is other than patient:

Subscriber's First Name _____ Subscriber's Last Name _____

Subscriber's Phone Number _____ Subscriber's Birth Date _____

Subscriber's Address (if different from patient) _____

City _____ State _____ Zip _____

If you were in a car accident, complete sections 2, 3, and 4.

2. Car Insurance of the Car You Were in during the Accident

PLEASE NOTE: This information is required in order to bill the insurance company. This will not affect your rates.

Policy Holder Name _____

Insurance Company Name _____ Policy No. _____

Insurance Company Address _____ Claim No. _____

Agent _____ Agent Phone No. _____

Has this insurance company been notified? () Yes () No

3. If You Were not in Your Own Car, What Insurance Do You Have on Your Own Car?

PLEASE NOTE: This information is required in order to bill the insurance company. This will not affect your rates.

Policy Holder Name _____

Insurance Company Name _____ Policy No. _____

Insurance Company Address _____ Claim No. _____

Agent _____ Agent Phone No. _____

4. Car Insurance of the Other Car That Was Involved in the Accident

Insurance Company Name _____ Policy No. _____

Insurance Company Address _____ Claim No. _____

Agent _____ Agent Phone No. _____

Policy Holder Name _____ Policy Holder Phone No. _____

Policy Holder Address _____

City _____ State _____ Zip _____

Make/Model of Other Vehicle if Known _____

If you were injured at your job, complete section 5.

5. Workers' Compensation Information

Employer at Time of Accident (same as present) or _____

Employer's Address _____ Employer's Phone # _____

City _____ State _____ Zip _____

Employer's Insurance Carrier _____

Insurance Carrier's Address _____

City _____ State _____ Zip _____

Claim # _____ Insurance Carrier Phone # _____

Car Accident Questionnaire

Date _____

Please fill out the answers to the following questions to the best of your ability. If you have difficulty with any questions or are unsure of how best to answer, please discuss those questions with the doctor before answering.

() Mr. () Ms. Last Name _____ First Name _____

Age _____ Weight _____ Height _____

Are you:

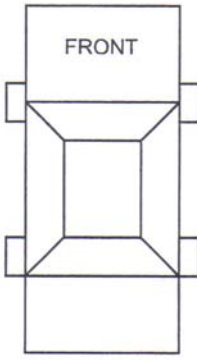
() Married () Single () Divorced () Separated () Widowed () Living with a significant other

Are you a parent? () No () Yes with 1 2 3 4 5 6 children

Occupation _____ For how long? Years _____ Months _____

Make and model of the car you were in _____ Year _____

Date of Accident (____ / ____ / ____)
MM DD YYYY

<p>(Check one for each question)</p> <p>You were:</p> <p><input type="checkbox"/> The driver</p> <p><input type="checkbox"/> Front seat passenger</p> <p><input type="checkbox"/> Rear seat passenger</p> <p>Your car was struck:</p> <p><input type="checkbox"/> In the rear</p> <p><input type="checkbox"/> In the right rear</p> <p><input type="checkbox"/> In the left rear</p> <p><input type="checkbox"/> In the driver's side</p> <p><input type="checkbox"/> In the passenger's side</p> <p><input type="checkbox"/> In the front</p> <p><input type="checkbox"/> In the left front</p> <p><input type="checkbox"/> In the right front</p> <p><input type="checkbox"/> Other (explain below)</p> <p>Your car was struck by:</p> <p><input type="checkbox"/> A car</p> <p><input type="checkbox"/> A van</p> <p><input type="checkbox"/> A pickup truck</p> <p><input type="checkbox"/> A bus</p> <p><input type="checkbox"/> Another vehicle (what type)</p>	 <p style="text-align: center;">Draw an arrow to show where you were hit.</p>	<p>Your car was:</p> <p><input type="checkbox"/> Stopped at a traffic signal</p> <p><input type="checkbox"/> Stopped at a stop sign</p> <p><input type="checkbox"/> Stopped for a pedestrian</p> <p><input type="checkbox"/> Stopped in traffic</p> <p><input type="checkbox"/> At a complete stop</p> <p><input type="checkbox"/> Slowing down for a traffic signal</p> <p><input type="checkbox"/> Slowing down for a stop sign</p> <p><input type="checkbox"/> Slowing down for a pedestrian</p> <p><input type="checkbox"/> Slowing down for traffic</p> <p><input type="checkbox"/> Slowing down to turn</p> <p><input type="checkbox"/> Slowing down to park</p> <p><input type="checkbox"/> Making a right-hand turn</p> <p><input type="checkbox"/> Making a left-hand turn</p> <p><input type="checkbox"/> Making a U-turn</p> <p><input type="checkbox"/> Moving with the flow of traffic</p> <p><input type="checkbox"/> Other (explain below)</p>
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Additional Information on Collision (if the information given already does not describe the accident fully):

Have you had any accidents or injuries since this accident? ()No ()Yes—please explain

Please complete one of the following statements

Since the accident, my injury prevents me from _____

(example: Since the accident, my injury prevents me from playing basketball, helping around the house, and running. I did these things often before the injury.)

Since the accident, I have been unable to _____

(example: Since the accident, I have been unable to go to school, make the beds, clean the house, drive the car, or put on my shoes, socks, or pants.)

Since the accident, I have had difficulty _____

(example: Since the accident, I have had difficulty standing, working, sleeping, bending, and lifting my child.)

Please answer the following questions

Were you wearing your seatbelt? ()Yes ()No
Did your head hit the headrest? ()Yes ()No ()Unsure
Did an airbag deploy and hit you? ()Yes ()No
Your head position: ()Straight-ahead ()Turned to the left ()Turned to the right ()Unsure
Your body position: ()Sitting squarely in your seat ()Twisted in your seat ()Leaning forward ()Leaning to the side
Did you hit your head on the ()Steering wheel ()Windshield ()Visor ()Roof ()Side window
Were you aware of the impending collision? ()Yes ()No Braced for impact? ()Yes ()No
Were you rendered unconscious? ()Yes ()No Badly shaken? ()Yes ()No
Did you go () To the hospital by ambulance immediately after the accident () To the hospital using your own transportation immediately after the accident () To the hospital, but some days later. If so, when (___ / ___ / ___) () To a private doctor. If so, when (___ / ___ / ___)

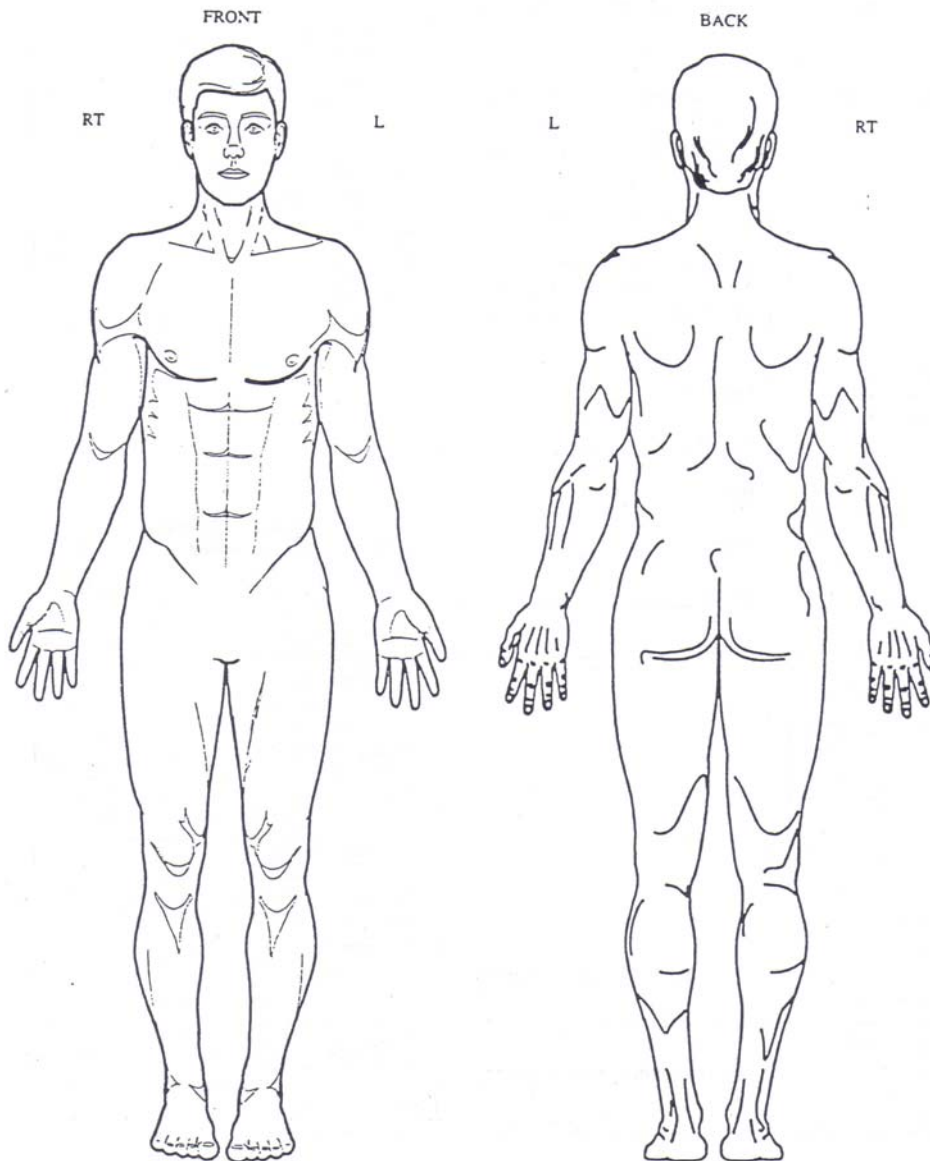
Name of hospital or doctor? _____

Symptoms Diagram

Patient's Name _____ Date _____

Please complete the following "Symptoms Diagram" by using letters below to indicate on the diagram your areas of symptoms: _____
Patient's Signature _____

- Pain (P)
- Tingling (T)
- Numbness (N)
- Burning (B)
- Stiffness (S)



Direct Payment Authorization

DATE (____ / ____ / ____)
 MM DD YYYY

Patient Account # _____

Insurance Information

Insurance company _____

Policy number _____

Claim number _____

Authorization To Pay Doctor Directly

I hereby instruct and direct my insurance company to pay by check made payable to "King Street Back & Neck Care" and mail to:

King Street Back & Neck Care
P.O. Box 16727
Alexandria VA 22302

If my current policy prohibits direct payment to a doctor, then I hereby also instruct and direct my insurance company to make the check payable to me and mail it as follows:

(Policyholder's name)
King Street Back & Neck Care
P.O. Box 16727
Alexandria VA 22302

I instruct my insurance company to pay, in accordance with my above instructions, all the professional or medical expense benefits allowable, and otherwise payable to me under my insurance policy as payment towards the total charges for the professional service rendered.

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

I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

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 King Street Back & Neck Care's attorney.

Signature of Policyholder

Witness

Signature of Claimant, if other than policyholder

Medical Reports And Doctor's Lien

I do hereby authorize King Street Back and Neck Care (Dr. Steven Trauben) to furnish you, my attorney, with a full report of the 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 said doctor such sums as may be due and owing him for medical service rendered me both by reason of this accident and by reason of any other bills that are due the office and to withhold such sums from any settlement, judgment, or verdict as may be necessary to adequately protect said doctor. And I hereby further give a lien on myself, as the result of the injuries for which I have been treated or injuries in connection therewith.

I agree never to rescind this document and that a rescission will not be honored by my attorney. I hereby instruct that in the event another attorney is substituted in this matter, the new attorney honor this lien as inherent to the settlement and enforceable upon the case as if it were executed by him/her.

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 his awaiting payment. And I further understand that such payment is not contingent on any settlement, judgment, or verdict by which I may eventually recover said fee.

I 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.

Date

Patient's Signature

Patient's Name (Printed)

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 above-named.

Dated

Attorney's Signature

Attorney's Name (Printed)