COASTAL CHIROPRACTIC
Dr. Robert LaDuca, D.C.
28467 DuPont Blvd. Millsboro, DE 19966

Auto Injury New Patient Information:

First Name: _____Last Name_____

Address: _____

City: _____ State: _____ Zip Code: _____

Cell Phone: _____ Home Phone: _____

Date of Birth: _____ Age: _____

Gender: ___Male ___Female Marital Status: ___Single ___Married ___Other: _____

How did you hear about our office? _____

Primary Care Doctor: _____Phone: _____

Are you working with an attorney? Name: _____Phone: _____

Patient Employer Data:

Employment Status: __Employed __Full time __Part time __Retired __Unemployed __Homemaker

Employer Name: _____
Job title/Position: _____

Auto Insurance and Claim Information: *REQUIRED This should be YOUR insurance, regardless of fault

Have you completed and returned the Personal Injury Protection Application for medical bills to the adjuster? Yes No

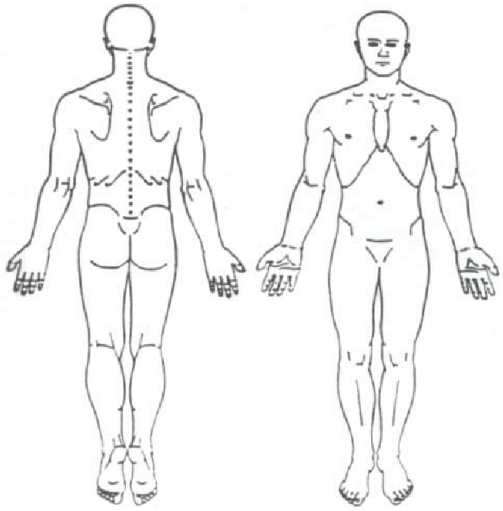
Auto Insurance: _____
Address: _____
Phone: _____
Claim Number #: _____
Adjuster Name: _____
Phone: _____EXT:_____ Email: _____

Health Insurance Information:

Primary Health Insurance: _____
Address: _____
Phone: _____
Member/Subscriber ID#: _____
Does your insurance plan require prior authorization for specialist visits? _____

Patient Symptoms:

Please mark where your pain/symptoms are:



Please grade your pain on a scale of 0-10: Circle how frequent the pain is present:

0=NO PAIN, 10=EXTREME PAIN

NECK: 0 1 2 3 4 5 6 7 8 9 10 Seldom-Intermittent-Frequent-Constant

Upper/Mid Back: 0 1 2 3 4 5 6 7 8 9 10 Seldom-Intermittent-Frequent-Constant

Lower Back: 0 1 2 3 4 5 6 7 8 9 10 Seldom-Intermittent-Frequent-Constant

When did your symptoms appear? _____

Is the condition getting progressively worse? _____

Type of pain:

___SHARP ___DULL ___THROBBING ___NUMBNESS ___ACHING ___SHOOTING
___BURNING ___TINGLING ___CRAMPING ___STIFNESS ___SWELLING ___OTHER_____

Does it interfere with ___SLEEP ___DAILY ROUTINE ___RECREATION?

Activities that are painful to perform:

___SITTING ___STANDING ___WALKING ___BENDING ___LYING DOWN ___OTHER _____

What treatments have you already received for your condition?
___ MEDICATIONS ___PHYSICAL THERAPY ___SURGERY

Name of other doctors that have treated you for your condition:
_____Phone: _____

Last Chiropractic exam/treatment: _____

Health History: Please check any of the following that you have or have had:

___AIDS/HIV	___Glaucoma	___Pacemaker	___Alcoholism	___Goiter	___Parkinson's Disease
___Allergy Shots	___Lupus	___Pinched nerve	___Anemia	___Gout	___Hepatitis
___Pneumonia	___Anorexia	___Heart Disease	___Polio	___Appendicitis	___Herniated Disc
___Prostate Problem	___Arthritis	___Hernia	___Prosthesis	___Asthma	___High Blood Pressure
___Psychiatric Care	___Bleeding disorder	___Herpes	___Rheumatoid Arthritis	___Breast Lump	___Kidney Disease
___Rheumatic Fever	___Bronchitis	___High Cholesterol	___Scarlet Fever	___Bulimia	___Measles
___STD	___Cancer	___Liver Disease	___Stroke	___Cataracts	___Miscarriage
___Suicide Attempt	___Migraines	___Thyroid Problems	___Fibromyalgia	___Chicken Pox	___Multiple Sclerosis
___Tonsillitis	___Diabetes	___Mononucleosis	___Tuberculosis	___Emphysema	___Osteoporosis
___Tumors, Growths	___Epilepsy	___Mumps	___Typhoid Fever	___Fractures	
___Ulcers	___Anxiety	___Depression	___Bipolar Disorder	___Shingles	

Other: _____

Are you pregnant? ___Yes ___No ____ Not Sure ____ Due Date _____

Exercise:
____None ____Occasionally ____Daily ____Heavy

Work Activity:
___ Sitting ___Standing ___Light Labor ___Heavy Labor

Habits:
___Smoking; Packs/Day___ _____Alcohol; Drinks/Week _____ Coffee/caffeine drinks; Cups/Day _____

Previous Injuries: Please include description and dates

Falls: _____
Head Injuries: _____
Broken Bones: _____
Dislocations: _____
Surgeries: _____

Medications:_____
_____
_____

Family History:
Please describe any relevant, immediate family history, e.g. cancer, diabetes, heart disease, etc.
_____
_____
_____

Patient's Name: _____

Accident Information:

Date of Accident: _____ Time: _____ a.m. /p.m.

Driver of Car: _____ Number of persons in the vehicle: _____
Where were you seated? _____ Did the police arrive? Yes___ No___
Were EMT's at the scene? Yes___ No___ Was an accident report completed? Yes___ No___
What state did the accident occurred in: Delaware___ Other (name) _____

Year and Model of Car: _____

Type of Car: Compact___ Mid-Size___ Full Size___ Compact Truck: ___ Full Truck___ Minivan___ Full Size Van___
Small SUV___ Large SUV___ Motorcycle___ Motor Home___ Bicycle___ Other_____

Other Vehicle: Compact___ Mid-Size___ Full Size___ Compact Truck___ Full Truck___ Minivan___ Full Size Van___
Small SUV___ Large SUV___ Motorcycle___ Motor Home___ Bicycle___ Other_____

Visibility at time of accident: Poor___ Fair___ Good___ Clear___ Other_____

Conditions at time of accident: Icy___ Rainy___ Foggy___ Wet___ Clear___ Dark___ Snowing___ Other:_____

What was your vehicle doing just prior to the accident?
Stopped at a red light ___ At a complete stop__ Slowing down to stop ___ Increasing speed ___ Changing lanes___
Merging into traffic___ Traveling at a constant speed___ Backing up ___

Traveling at an approximate speed of:
Stopped ___ Speed Unknown ___ Moving very slowly (less than 15 mph) ___ Moving slowly (up to 25 mph) ___
Moving at a moderate speed (up to 40 mph) ___ Moving at an increased speed (up to 65 mph) ___
Moving at an excessive speed (> 65 mph) ___

Who hit who?
You were struck by another vehicle ____ You struck another vehicle ____ You struck a stationary object____
You were struck by another vehicle and forced into another vehicle____ other:_____

What was your vehicle's point of impact?
Front___ Rear___ Right Side___ Left Side___ Right Front___ Left Front___ Right Rear___ Left Rear___

Type of accident:
Head on collision___ Broad side collision___ Rear end Collision___ Front impact, rear ended car in front___
Other:_____

What was other vehicle doing just prior to the accident?
Not Sure____ Stopped at a red light ____ At a complete stop____ Slowing down to stop ____ Increasing speed ____
Changing lanes____ Merging into traffic____ Traveling at a constant speed____ Backing up ____

Traveling at an approximate speed of:
Speed Unknown ___ Stopped ___ Moving very slowly (less than 15 mph) ___ Moving slowly (up to 25 mph) ___
Moving at a moderate speed (up to 40 mph) ___ Moving at an increased speed (up to 65 mph) ___
Moving at an excessive speed (> 65 mph) ___

What was their vehicle's point of impact?
Front___ Rear___ Right Side___ Left Side___ Right Front___ Left Front___ Right Rear___ Left Rear___

Were you wearing seat restraints?
Full lap and shoulder restraint___ Lap restraint only___ Shoulder restraint only___ I was not wearing a restraint___

What position was your vehicle's headrest in?
Lowest position___ Middle position ___Highest position___ No headrest in vehicle___ Not Sure___

Did your vehicle's air bags deploy? Yes___ No___ **Did your seat break?** Yes___ No___

Were you prepared for the impact?
Came as a complete surprise___ Aware and braced for impact___ Aware but not braced for impact___ Not sure___

What position was your head and neck at the time of the accident?
Straight forward___ Looking down___ Head turned right___ Head turned left___ Turned around___
Toward rear view mirror___ Other: _____

What happened to your body at the moment of impact?
Body was tensed for impact___ Body whipped forward/backward___ Body torqued and twisted___
Body was thrown over seat___ Body was thrown from vehicle___ Body was pinned in vehicle___
Body was thrown from side to side___ Body was cut and bruised___ Other: _____

What was the position of your arms at the time of impact? _____

Did any part of your head or body strike any part of the vehicle? Yes___ No___ If yes, describe:_____

What was your mental/emotional state immediately following the accident?
Unconscious___ Disoriented___ Shaken up___ Shaken up & Disoriented___ Dazed___ Dizzy___ Other:_____

Were any personal items or clothing such as glasses, hat, etc. thrown about the vehicle?
Yes__ No__ Not Sure__ If yes, describe: _____

Did you have any cuts or bruises from the accident? Yes__ No__
If yes, describe: _____

Did you feel any pain immediately after the accident? Yes__ No__
If yes, describe: _____

How did you feel later that day/night? _____

How did you feel the next day(s)? _____

How much property damage to your vehicle?
Minor___ Moderate___ Extensive___ Totaled___ Vehicle was towed from scene ___

Did you receive medical attention at the scene of the accident? Yes__ No__

Where did you go immediately following the accident?
Taken to hospital by ambulance___ Driven to hospital___ Drove to hospital___ Home___ Medical doctor___ Resumed daily activities___ Other: _____

If you went to the hospital, when did you go?
Same day____ Next day____ Several days later___ 1 Week later___ Several weeks later___ Other_____

What was done at the hospital?
X-rays: Yes__ No__ If yes, of what body part(s)?_____
CT Scan: Yes__ No__ If yes, of what body part(s)? _____
MRI: Yes__ No__ If yes, of what body part(s)? _____

Were you prescribed medication? Yes__ No__ If yes, describe:_____

Were you admitted? Yes__ No__

Where recommendations made? Yes___ No___
If yes, what follow up was recommended: Primary care doctor___ Physical therapy___
Orthopedic surgeon___ No work___ Other: _____

Other doctor/hospital /clinic seen: _____ Date: _____
Describe treatment/recommendations/prescriptions:
_____
_____

Other doctor/hospital /clinic seen: _____ Date: _____
Describe treatment/recommendations/prescriptions:
_____
_____

Other doctor/hospital /clinic seen: _____ Date: _____
Describe treatment/recommendations/prescriptions:
_____
_____

Occupation: _____

Have you missed time from work? Yes___ No___
If yes, how much time have you missed? _____

Have you returned to work yet? Yes___ No___
If yes, any work restrictions? _____

Have you ever had the same or similar condition or symptoms prior to this accident? Yes___ No___

If yes, describe:_____

_____

Please describe any prior trauma or accidents and any residuals:

_____

_____

_____

_____

Activities of Daily Living

Mark all of the below functions that you are unable to perform or are having difficulty performing due to each of the conditions indicated above.

Personal Care:

Eating __ Dressing __ Grooming/Hygiene __ Bathing __ Eliminating __

Additional Info: _____

Communication:

Hearing __ Speaking __ Reading __ Writing __ Using a keyboard __

Additional Info: _____

Activity:

Sleeping __ Standing __ Walking __ Sitting __ Running __ Working __ Heavy lifting __ Medium lifting __

Light lifting __ Lifting weights __ Having sex __ During sports __ Working around the house __

Working on hobbies __ Exercising __ Additional Info: _____

Sensory:

Hearing __ Seeing __ Feeling __ Tasting __ Smelling __ Additional Info: _____

Recreation/Travel:

Driving a car __ Riding in a car __ Riding in a boat __ Traveling in an airplane __

Traveling in a train __ Riding a bike__ Additional Info: _____

Social Activities:

Participating in group activities __ Speaking in public __ Emotional Stability __

Additional Info: _____

Other:_____

_____

_____

_____

_____

_____

COASTAL CHIROPRACTIC AUTHORIZATION FORM

PATIENT NAME_____

RELEASE OF INFORMATION

I HEREBY AUTHORIZE COASTAL CHIROPRACTIC TO REALEASE MEDICAL AND FINANCIAL DATA TO MY INSURANCE CARRIERS, OTHER MEDICAL FACILITEIS AND ATTORNEY(S).

RESPONSIBILITY OF BILL

THE UNDERSIGNED HEREBY ACCEPTS FULL FINANCIAL RESPONSIBILITY FOR CHARGES AND SERVICES RENDERED REGARDLESS OF INSURANCE COVERAGE.

THE UNDERSIGNED UNDERSTANDS THAT SERVICES ARE RENDERED AND CHARGED TO YOU (THE PATIENT) AND NOT TO YOUR INSURANCE COMPANY. COASTAL CHIROPRACTIC DOES NOT ACCEPT TOTAL RESPONSIBILITY FOR COLLECTING AN INSURANCE CLAIM OR NEGOTIATING A DISPUTED SETTLEMENT. IT IS THE FINANCIAL OBLIGATION OF THE UNDERSIGNED TO BE RESPONSIBLE FOR ANY CHARGES OR SERVICES NOT COVERED BY INSURANCE FOR WHICH PAYMENT IS DENIED THROUGH ANY UTILIZATION REVIEW OR PRE-CERTIFICATION PROCEDURES, OR ANY REMAINING BALANCE UPON COMPLETION OF A SETTLEMENT. THE UNDERSIGNED ALSO AGREES THAT THIS OBLIGATION SHALL EXIST REGARDLESS OF PRIVATE CONTRACTUAL AGREEMENT BETWEEN THE PATIENT AND ANY INSURANCE CARRIER, ATTORNEY OR THIRD PARTY NOT SIGNING THIS AGREEMENT.

CONSENT FOR TREATMENT OF A MINOR CHILD

CONSENT IS HEREBY GIVEN BY THE UNDERSINGED FOR CHIROPRACTIC TREATMENT, X-RAYS AND DIAGNOSTIC STUDIES AS ORDERED BY THE DOCTORS AND THERAPIES (THERAPEUTIC MASSAGE, ELECTRICAL STIMULATION, ICE/HEAT THERAPY, HYDRO-THERAPY, THERAPEUTIC EXERCISES) PERFORMED BY THE TECHNICAL STAFF OF COASTAL CHIROPRACTIC. THE UNDERSIGNED STATES THAT HE/SHE IS THE PATIENT'S LEGAL GUARDIAN**.**

AUTHORIZATION FOR PAYMENT OF INSURANCE BENEFITS TO PROVIDER

I HEREBY IRREVOCABLY AUTHORIZE PAYMENT OF MY MEDICAL BENEFITS OTHERWISE PAYABLE TO ME TO BE MADE PAYABLE AND MAILED DIRECTLY TO COASTAL CHIROPRACTIC FOR PROFESSIONAL SERVICES RENDERED. NO OTHER THIRD PARTY, INCLUDING MY ATTORNEY, SHOULD RECEIVE PAYMENT OF MY BILLS EXCEPT THIS OFFICE FOR THE REMAINDER OF THIS CLAIM. IT WILL BE ASSUMED AND RELIED UPON THAT THE INSURANCE CARRIER HAS AGREED TO AND ACKNOWLEDGED MEDICAL COVERAGE AND WILL SEND PAYMENT DIRECTLY TO THIS OFFICE.

_____

PATIENT OR GUARDIAN'S SIGNATURE **RELATIONSHIP TO PATIENT** **DATE**

COASTAL CHIROPRACTIC

28467 Dupont Boulevard
Millsboro, DE 19966
Phone 302-933-0700
Fax 302-933-0800

Release of Medical Records

Patient Name (please print):_____

Date of Birth: _____/_____/_____

I hereby authorize _____to release all medical records, or those requested concerning the dates of treatment on or about _____ to Coastal Chiropractic, LLC.

Please Fax the following requested information to: 302-933-0800

- **IMAGING ONLY: X-Ray, MRI, CT Scans only (unless otherwise requested below)**
- **Other:** _____

I understand that this request for release of information stands effective for 120 days. This request may be revoked at any time but is not retroactive for requests that have been complied within good faith. This authorization may be revoked by written request to an authorized representative of Coastal Chiropractic.

X_____ _____/_____/_____

Patient's Signature **Date**

X_____ _____ _____/____/____

Signature of Legal Guardian **Relationship to Patient** **Date**

Disclosure of the specific information for release is limited to the above mentioned recipient only. Federal regulation, 42 CFR Part 2, prohibits the re-disclosure of the enclosed information unless the consent expressly permits further disclosure or the re-disclosure is otherwise permitted under regulations.

COASTAL CHIROPRACTIC HIPAA COMPLIANCE/PATIENT CONSENT FORM

Patient Name_____

Notice of our privacy practices provides information about how we may use or disclose protected health information about you. This notice contains a patient's rights describing your rights under the law.

You have the right to restrict how your protected health information is disclosed for treatment, payment or other healthcare operations.

Authorization is voluntary and you may change or revoke this consent in writing, signed by you, however, if you do revoke the authorization, it will not have any effect on any actions taken by Coastal Chiropractic, LLC prior to the receipt of the revocation.

Please answer each question to the protected health information that may be used or disclosed on your behalf for treatment, payment or other healthcare operations.

May we disclose medical records to primary care physician or referring physician?
YES NO

May we disclose information about your diagnosis, treatment and services you received to your healthcare insurance for purposes of reimbursement for services rendered?
YES NO

May we phone or send a text message to confirm or update you about an appointment?
YES NO

May we leave a message on your answering machine at home or cell phone?
YES NO

May we discuss your medical condition with any member of your family?
YES NO

_____ _____

Signature of patient or representative Date