SYNAPSE CHIROPRACTIC

Automobile/PI Accident or Work Comp Questionnaire

Patient's Name **Date of Birth** **HR#:**

Dear Patient:
This information is considered confidential. Your answers will help us determine if chiropractic care can help your condition. We will not accept your case if we do not believe your condition will respond satisfactorily to care. In order for us to understand your condition properly, please be as neat and accurate as possible while completing this form.
Thank you.

Please answer all questions completely.

Please explain in detail how your accident happened: _____

_____

_____

What were the time and date of present injury? _____

Where did you feel pain immediately after the accident? _____

List the extent of your injuries as you know them: _____

_____

_____

Did you require post-accident hospitalization? ☐ Yes ☐ No

Check symptoms you have noticed since the accident:

☐ Headache	☐ Dizziness	☐ Depression	☐ Fatigue
☐ Light Bothers Eyes	☐ Buzzing in Ears	☐ Diarrhea	☐ Neck Pain
☐ Head Seems to Heavy	☐ Memory Loss	☐ Feet Cold	☐ Neck Stiff
☐ Pins and Needles in Arms	☐ Ears Ring	☐ Hands Cold	☐ Fainting
☐ Sleeping Problems	☐ Back Pain	☐ Face Flushed	☐ Loss of Balance
☐ Pins and Needles in Legs	☐ Constipation	☐ Tension	☐ Nervousness
☐ Numbness in Fingers	☐ Loss of Smell	☐ Fever	☐ Irritability
☐ Numbness in Toes	☐ Loss of Taste	☐ Chest Pain	☐ Cold Sweats
☐ Shortness of Breath	☐ Stomach Upset		

Symptoms other than above: _____

_____

Where were you taken after the accident? _____

Hospitalized? ☐ Yes ☐ No If yes, admitted? _____ How long? _____

Name of Hospital: _____

Name of Doctor(s): _____

What treatment was given? _____

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Was any other doctor consulted after your accident? ☐ Yes ☐ No

If so, what was the doctor's name? _____ D.C., M.D., D.O., D.D.S.

What was the diagnosis? _____

What treatment was given? _____

How often did you see the doctor? _____

How long did you see the doctor? _____

Have you ever had any complaints in the involved area before? ☐ Yes ☐ No

If so, what were the complaints? _____

Before the injury were you capable of working on an equal basis with others your age? ☐ Yes ☐ No

Are your work activities restricted as a result of this accident? ☐ Yes ☐ No

Since this injury are your symptoms … ☐ Improving? ☐ Getting worse? ☐ Same?

Driver of other vehicle (if any):

Name _____ Insurance Company _____ Policy No. _____

Driver of vehicle in which you were injured (if applicable):

Name _____ Insurance Company _____ Policy No. _____

Name of your insurance adjustor _____

Have you retained an attorney? ☐ Yes ☐ No

If so, his/her name and address_____

You were heading North/ East/ South/ West on _____ (street or highway)

Other vehicle was heading North/ East/ South/ West on _____ (street or highway)

Were police notified? ☐ Yes ☐ No

Were you knocked unconscious? ☐ Yes ☐ No If yes, for how long? _____

You were struck from Behind/ Front/ Left Side/ Right Side _____

You were Driver/ Passenger/ Front seat/ Back Seat/ Using seat belts _____

Patient Signature _____ Date _____

Doctor Signature _____ Date _____

ASSIGNMENT OF BENEFITS, ASSIGNMENT OF RIGHTS TO PURSUE PERSONAL INJURY, WORK COMP, ERISA, AND OTHER LEGAL AND ADMINISTRATIVE CLAIMS ASSOCIATED WITH MY HEALTH INSURANCE AND /OR HEALTH BENEFIT PLAN (INCLUDING BREACH OF FIDUCIARY DUTY) AND DESIGNATION OF AUTHORIZED REPRESENTATIVE

Provider Name: Dr. Ranvir Sahota D.C.
Clinic: Synapse Chiropractic, A Sahota Corporation
Address: 6508 Lonetree Blvd Ste 101 Rocklin, CA 95765

I hereby assign and convey directly to the above-named health care provider, as my designated authorized representative, any and all medical benefits and/or any insurance reimbursement, if any, otherwise payable to me for services, treatments, therapies, and/or medications rendered or provided by the above-named health care provider, regardless of its managed care network participation status. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the above-named health care provider to release all medical information necessary to process my claims. Further, I hereby authorize my plan administrator fiduciary, insurer, and/or attorney to release to the above-named health care provider any and all Plan documents, summary benefit description, insurance policy, and/or settlement information upon written request from the above-named health care provider or its attorneys in order to claim such medical benefits.

In addition to the assignment of all medical benefits and/or insurance reimbursement above, I also assign and/or convey to the above named health care provider any legal or administrative claim or chose an action arising under any group health plan, employee benefits plan, health insurance or tort feasor insurance concerning medical expenses incurred as a result of the medical services, treatments, therapies, and/or medications I receive from the above-named health care provider (including any right to pursue those legal or administrative claims or chose an action). This constitutes an express and knowing assignment of ERISA breach or fiduciary duty claims and other legal and/or administrative claims.

I intend by this assignment and designation of authorized representative to convey to the above-named provider all of my rights to claim (or place a lien on) the medical benefits related to the services, treatments, therapies, and/or mediations provided by the above-named health care provider, including rights to any settlement, insurance or applicable legal or administrative remedies (including damages arising from ERISA breach of fiduciary duty claims). The assignee and/or designated representative (above-named provider) is given the right by me to (1) obtain information regarding the claim to the same extent as me; (2) submit evidence; (3) make statements about facts or law; (4) make any request including providing or receiving notice of appeal proceedings; (5) participate in any administrative and judicial actions and pursue claims or chose in action or right against any liable party, insurance company, employee benefit plan, health care benefit plan, or plan administrator. The above-named provider as my assignee and my designated authorized representative may bring suit against any such health care benefit plan, employee benefit plan, plan administrator or insurance company in my name with derivative standing at provider's expense.

Unless revoked, this assignment is valid for all administrative and judicial reviews under PPACA (health care reform legislation), ERISA, Medicare and applicable federal and state laws. A photocopy of this assignment is to be considered valid, the same as if it was the original.

I HAVE READ AND FULLY UNDERSTAND THIS AGREEMENT.

_____

Patient Signature

_____

Date