# DESERT PINES REHABILITATION
AUTO INJURY CARE

## Welcome To Our Office!

**New Patient Information**
(Or Update Information)

## PATIENT INFORMATION

Date ____/____/____ Patient Name _____
(Last) (First) (Init.)

Date of Birth ____/____/____ Age _____ Sex: ❒ M ❒ F

Social Security # _____ Marital Status: ❒ Single ❒ Married ❒ Divorced ❒ Widowed

Address _____ Apt # _____

City _____ State _____ Zip Code _____

Home # _____ Mobile # _____ Work # _____

E-Mail: _____ Occupation _____ Employer _____

Primary Physician _____ Phone # _____ Fax # _____

Emergency Contact _____ Relationship _____ Phone # _____

Spouse Name _____ Date of Birth ____/____/____ Social Security # _____

## CHIEF COMPLAINTS

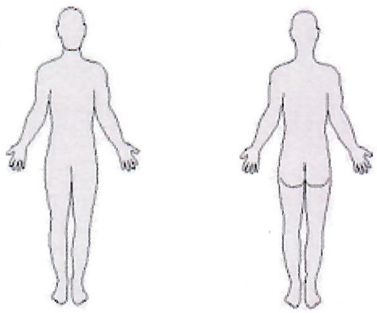
Chief complaints _____

Cause of chief complaints _____

When did your symptoms appear? _____

What treatment have you received for this condition?

❒ Medical ❒ Chiropractic ❒ Physical Therapy ❒ None



Shade in your area of Complaint

Severity of your pain on a scale from **0** (no pain) to **10** (severe pain) _____

Are you pregnant? ❒ Yes ❒ No ❒ Male

Medications you are currently taking _____ ❒ None

## MEDICAL HISTORY

Injuries _____ Date: _____

Illnesses _____ Date: _____

Surgeries _____ Date: _____

## INSURANCE INFORMATION

**Primary Insurance**: _____ Telephone # _____

Address _____ City _____ State _____ Zip _____

Name of Policy Holder _____ Date of Birth _____/_____/_____

Relationship to Patient _____ Employer _____

Member Id # _____ Group Id # _____ Social Security # _____

**Secondary Insurance**: _____ Telephone # _____

Address _____ City _____ State _____ Zip _____

Name of Policy Holder _____ Date of Birth _____/_____/_____

Relationship to Patient _____ Employer _____

Member Id # _____ Group Id # _____ Social Security # _____

## HIPPA/ INSURANCE AUTHORIZATION & RELEASE

# HIPAA COMPLIANCE

- Your personal health information cannot be shared unless to prevent serious threat to your health or others.
- Your personal health information may be disclosed, if required to do so by law.
- You have the right to access your medical file and billing records.
- You have the right to request that we amend your information.
- You may revoke any written authorization given to us.
- All requests must be presented to this office in writing.

I allow my treatment to be discussed with _____ Relationship _____

# INSURANCE ASSIGNMENT AND RELEASE

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to **DESERT PINES REHABILITATION.** I authorize **DESERT PINES REHABILITATION** to release any information required to process my claims. I understand it is my responsibility to make sure my account is paid by my insurance company. I have verified with my insurance company that **DESERT PINES REHABILITATION** is a participating provider. I understand that I am fully financially responsible if there are any unpaid claims by my insurance company for any reason.

Patient Signature: _____ Date: _____

# MEDICARE / MEDIGAP AUTHORIZATION

I request that payment of authorized Medicare benefits and (if applicable) Medigap benefits, be made either to me or on my behalf to: **DESERT PINES REHABILITATION** for any services furnished to me by that provider. To the extent permitted by law, I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicare Services, my Medigap insurer and their agents any information needed to determine these benefits for related services.

Patient Signature: _____ Date: _____

## VEHICLE ACCIDENT INFORMATION

Patient Name: _____ Date of Accident: ____/____/____
(Last) (First) (Init)

Describe the accident:_____

Where you the: ❒ Driver ❒ Front passenger ❒ Rear Passenger ❒ Pedestrian ❒ Other _____

Model of vehicle you were in: _____

Speed of your vehicle: _____

Model of the other vehicle: _____

Speed of the other vehicle: _____

Show how the accident happened

Were you wearing your seat belt? ❒ Yes ❒ No

At time of impact you were looking: ❒ Straight Ahead ❒ Ahead, but not sure ❒ Down ❒ Left ❒ Right

Did you brace yourself for the impact? ❒ Yes ❒ No

Did your airbag deploy? ❒ Yes ❒ No ❒ No airbag

Did your head/body strike anything inside the vehicle? ❒ No ❒ Yes My _____ struck the _____

Were you unconscious immediately after the accident? ❒ No ❒ Yes ❒ Unsure

Did the police come to the accident site? ❒ Yes ❒ No Was a report filed? ❒ Yes ❒ No ❒ Unsure

Visible damage to your vehicle: ❒ Unknown ❒ No visible damage ❒ Minor ❒ Moderate ❒ Heavy ❒ Totaled

Visible damage to other vehicle: ❒ Unknown ❒ No visible damage ❒ Minor ❒ Moderate ❒ Heavy ❒ Totaled

Was your vehicle towed from the scene? ❒ Yes ❒ No ❒ Unsure

Did an ambulance/paramedics come to the accident site? ❒ Yes ❒ No

How did you leave the accident site? ❒ Ambulance ❒ Drove home ❒ Was driven home ❒ Was driven to hospital

Did you go to a hospital / doctor? ❒ No ❒ Yes Which one: _____ When: ____/____/____
Treatments received: ❒ Exam ❒ X-rays ❒ Injection ❒ Rx prescription ❒ Released ❒ Admitted

Home treatments: ❒ None ❒ Rest ❒ Home heat pack ❒ Home cold pack ❒ OTC Meds

Are your symptoms getting worse? ❒ Yes ❒ No ❒ Staying the same

Have you missed work due to this injury? ❒ No ❒ Yes How many days? _____

**Mark all symptoms you have had since your injury:**

| | | |
|---|---|---|
| ❒ Headache | ❒ Dizziness | ❒ Blurred Vision |
| ❒ Neck Pain | ❒ Arm Pain/ Numbness | ❒ Ringing in ears |
| ❒ Mid back pain | ❒ Chest/ Ribs Pain | ❒ Sleep loss |
| ❒ Low Back Pain | ❒ Leg Pain/ Numbness | ❒ Other_____ |

**Patient Signature** _____ **Date** ____/____/____

**D**ESERT **P**INES **R**EHABILITATION
3551 E. Bonanza Rd. #108 Las Vegas, NV 89110
Ph: 702-437-0800 Fax: 702-437-7857

**D**UTIES **U**NDER **D**URESS
**L**OSS **O**F **E**NJOYMENT **F**ORM

Patient Name_____ Date_____

My **WORK STATUS** is:

☐ Working ☐ Unemployed ☐ Homemaker ☐ Not working due to pain.

Why have you continued to work? ☐ I could lose my job if I took time off.
☐ I couldn't support my family otherwise.
☐ My business could fail if I took time off.

My **FAMILY STATUS** would best be described as:

☐ Single ☐ Single with Kids. Number of children at home: _____
☐ Spouse Only ☐ Spouse and Kids. Number of children at home: _____

Activities which cause **HEAD, NECK or ARMS** pain or difficulty.

☐ Almost any movement ☐ Looking while driving
☐ Lifting/carrying with arms ☐ Getting up from lying down
☐ Reading/concentrating ☐ Remembering

Activities which cause **BACK or LEGS** pain or difficulty.

☐ All movements ☐ Twisting
☐ Standing ☐ Prolonged sitting
☐ Walking ☐ Driving/traveling
☐ Climbing stairs ☐ Getting in or out of a car
☐ Bending ☐ Getting up from sitting

**GENERAL ACTIVITIES** which cause pain or difficulty.

☐ Working ☐ Yard work
☐ Household chores ☐ Caring for family/children
☐ Self-care ☐ Socializing
☐ Sleeping (Hours lost:_____) ☐ Sexual activity
☐ Other:_____