## SALL/MYERS MEDICAL – INTAKE INFORMATION FOR TREATING PATIENTS

Patient Was: Driver Front Passenger Rear Passenger Pedestrian If yes, please List	Last Name	First	Initial	_ Injured Body Area:
Johns Address	Today's Date	Date of Accident		_   1
Social Security # Marital Status # 4 Children Date of Birth HT WT AGE SEX Highest Level of Schooling What Country:  Were you employed at the time of the accident? Where: Describe your job: Act you fice to get treatment during the day? Health Insurance: Carrier: Address: Insured: Secondary Insurance Health Insurance: Does the patient own a car? Does anyone in the patient's household own a car?  If sumeone in the household owns a car, name of the insured Has the accident been reported? When? PP Insurance: Insured: Address: Relationship to the patient: Policy # Claim #: Adjuster: Phone: Fax #: Declaration Page: Police Report: Direver's Liense: Social Security Card: Green Card: Other: Accident Information (Check all that apply. Describe accident in patient's own words) Category: MVA Fall Down Treating Comp Other Accident Information (Check all that apply. Describe accident in patient's own words) Description of exactly what happened to the patient at the time of the accident: Description of exactly what happened to the patient at the time of the accident: Description of exactly what happened to the patient at the time of the accident: Description of exactly what happened to the patient at the time of the accident: Description of exactly what happened to the patient at the time of the accident: Description of exactly what happened to the patient at the time of the accident: Description of exactly what happened to the patient at the time of the accident: Description of exactly what happened to the patient at the time of the accident: Description of exactly what happened to the patient at the time of the accident: Description of exactly what happened to the patient at the time of the accident: Description of exactly what happened to the patient at the time of the accident: Description of exactly what happened to the patient at the time of the accident: Description of exactly what happened to the patient at the time of the accident: Description of exactly what happened to the patient at the time of the accident: Descri	Home Address			
Social Security # Marital Status # 4 Children Date of Birth HT WT AGE SEX Highest Level of Schooling What Country:  Were you employed at the time of the accident? Where: Describe your job: Act you fice to get treatment during the day? Health Insurance: Carrier: Address: Insured: Secondary Insurance Health Insurance: Does the patient own a car? Does anyone in the patient's household own a car?  If sumeone in the household owns a car, name of the insured Has the accident been reported? When? PP Insurance: Insured: Address: Relationship to the patient: Policy # Claim #: Adjuster: Phone: Fax #: Declaration Page: Police Report: Direver's Liense: Social Security Card: Green Card: Other: Accident Information (Check all that apply. Describe accident in patient's own words) Category: MVA Fall Down Treating Comp Other Accident Information (Check all that apply. Describe accident in patient's own words) Description of exactly what happened to the patient at the time of the accident: Description of exactly what happened to the patient at the time of the accident: Description of exactly what happened to the patient at the time of the accident: Description of exactly what happened to the patient at the time of the accident: Description of exactly what happened to the patient at the time of the accident: Description of exactly what happened to the patient at the time of the accident: Description of exactly what happened to the patient at the time of the accident: Description of exactly what happened to the patient at the time of the accident: Description of exactly what happened to the patient at the time of the accident: Description of exactly what happened to the patient at the time of the accident: Description of exactly what happened to the patient at the time of the accident: Description of exactly what happened to the patient at the time of the accident: Description of exactly what happened to the patient at the time of the accident: Description of exactly what happened to the patient at the time of the accident: Descri	Home Phone #	Work #		2
AGE   SEX   Parent/Guardian (If less than 18)   Parent/Guardian	Social Security #	Marital Status	# Children	
What Country:   S.	Date of Birth HT	WT A	GE SEX	_
More you employed at the time of the accident?   Where:	Parent/Guardian (If less than 18)			_   4
Describe your job:   And treatment during the day?   Health Insurance: Carrier:   Address:	Highest Level of Schooling	What Count	ry:	5
Describe your job:   Are you free to get treatment during the day?   Are you free to get treatment during the day?   Are you free to get treatment during the day?   Are you free to get treatment during the day?   Are you free to get treatment during the day?   Are you free to get treatment during the day?   Are you free to get treatment during the day?   Are you free to get treatment during the day?   Are you free to get treatment during the day?   Address:   Assembly to the patient own a car?   Does anyone in the patient's household own a car?   Hackensack   Hackensack   Avenue and the patient own a car?   Address:	Were you employed at the time of the	e accident? Where:		
Health Insurance: Carrier:	Describe your job:			
Paterson   Irvington   Paterson   Irvington   Paterson   Irvington   Paterson   Irvington   Paterson   Irvington   Paterson   Irvington   Hackensack   New Brunswick   Passaic   Union City   Passaic   Union City   Passaic   Union City   Passaic   Union City   Paterson   Irvington   Passaic   Union City   Passaic   Unio	Are you free to get treatment during	the day?		
Attach a copy of identification card for each insurer listed.  Attach a copy of identification card for each insurer listed.  PPI Insurance: Does the patient own a car?	Health Insurance: Carrier:	Address:		Office:
Irvington   Hackensack   Relations are for each insurer listed.   Irvington   Hackensack   Relationship to the patient own a car?   Does anyone in the patient's household own a car?   Passaic   New Brunswick   Passaic   Passaic   Union City   Union C				
New Brunswick   Passaic   Mens   Mens   Passaic   Mens   Mens   Mens   Passaic   Mens   M				
Has the accident been reported?   When?       Passaic   Union City   Address:       Union City	PIP Insurance: Does the patient own a	a car? Does anyone in the patient	's household own a car?	Hackensack
Has the accident been reported?   When?       Passaic   Union City   Address:       Union City	If someone in the household owns a	New Brunswick		
Patients Carrier				
Address:  Relationship to the patient:  Policy # Claim #:  Adjuster:				
Relationship to the patient:  Policy #	Address:			
Policy #				
Documentation required for all PIP Claims: (Copy all, front and back)   Insurance ID Card:				Social History:
Insurance ID Card:	Adjuster:	Phone:	_ Fax #:	Are you a smoker?
Driver's License: Social Security Card: Green Card: Other: Any Allergies to Medication?  Accident Information (Check all that apply. Describe accident in patient's own words)  Category: MVA Fall Down Treating Comp Other Patient Was: Driver Front Passenger Rear Passenger Pedestrian In a: Car Bus Truck Van Taxi Train Other Were you wearing a seat belt? Could the car be driven after the accident?  What is the first thing you remember after the accident? Do you think you suffered a loss of consciousness at the time of the accident?  Description of exactly what happened to the patient at the time of the accident:  Physical Medicine & Rehab Internist  Report Type: New Patient Treating Comp Consultation	Documentation required for all F	'IP Claims: (Copy all, front and back)	)	Yes No
Other:	Insurance ID Card:	Declaration Page:	Police Report:	If yes, How often
Accident Information (Check all that apply. Describe accident in patient's own words)  Category: MVA Fall Down Treating Comp Other Patient Was: Driver Front Passenger Rear Passenger Pedestrian In a: Car Bus Truck Van Taxi Train Other Were you wearing a seat belt? Could the car be driven after the accident? What is the first thing you remember after the accident? Do you think you suffered a loss of consciousness at the time of the accident? Description of exactly what happened to the patient at the time of the accident:  Physical Medicine & Rehab Internist  Report Type: New Patient Treating Comp Consultation  Consultation	Driver's License:	Social Security Card:		_
Category: MVA Fall Down Treating Comp Other Patient Was: Driver Front Passenger Rear Passenger Pedestrian In a: Car Bus Truck Van Taxi Train Other Were you wearing a seat belt? Could the car be driven after the accident? What is the first thing you remember after the accident? Do you think you suffered a loss of consciousness at the time of the accident? Description of exactly what happened to the patient at the time of the accident:  Physical Medicine & Rehab Internist  Report Type: New Patient Treating Comp Consultation	Green Card:	Other:	,	Any Allergies to Medication?
Category: MVA Fall Down Treating Comp Other Patient Was: Driver Front Passenger Rear Passenger Pedestrian In a: Car Bus Truck Van Taxi Train Other Were you wearing a seat belt? Could the car be driven after the accident? Do you think you suffered a loss of consciousness at the time of the accident? Description of exactly what happened to the patient at the time of the accident:  Description of exactly what happened to the patient at the time of the accident:  Report Type: New Patient Treating Comp Consultation	Accident Information (Check all	that apply. Describe accident in p	atient's own words)	Ves No
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Were you wearing a seat belt? Could the car be driven after the accident? Orthopedist Neurologist Neurologist Psychiatrist Physical Medicine & Rehab Internist New Patient Treating Comp Consultation Consultation Consultation Consultation Consultation Consultation	Patient Was: Driver Front Pa	assenger Rear Passenger Pe	destrian	If yes, please List
What is the first thing you remember after the accident?  What is the first thing you remember after the accident?  Do you think you suffered a loss of consciousness at the time of the accident?  Description of exactly what happened to the patient at the time of the accident:  Description of exactly what happened to the patient at the time of the accident:  Psychiatrist  Physical Medicine & Rehab  Internist  Report Type:  New Patient  Treating Comp  Consultation	In a: Car Bus Tru	ck Van Taxi Train Ot	her	Specialty Requested:
Do you think you suffered a loss of consciousness at the time of the accident?  Description of exactly what happened to the patient at the time of the accident:  Description of exactly what happened to the patient at the time of the accident:  Physical Medicine & Rehab Internist  Report Type:  New Patient  Treating Comp  Consultation	Were you wearing a seat belt?	Could the car be driven after the	accident?	
Description of exactly what happened to the patient at the time of the accident:  Description of exactly what happened to the patient at the time of the accident:  Psychiatrist  Physical Medicine & Rehab  Internist  Report Type:  New Patient  Treating Comp  Consultation	What is the first thing you remember	-		
Physical Medicine & Rehab  Internist  Report Type:  New Patient Treating Comp Consultation  Consultation	Do you think you suffered a loss of c			
Report Type:  New Patient Treating Comp Consultation	Description of exactly what happened			
Report Type:  New Patient Treating Comp Consultation				Physical Medicine & Rehab
New Patient Treating Comp Consultation				— Internist
New Patient Treating Comp Consultation				_
Treating Comp  Consultation				— Report Type:
Consultation				— New Patient
Consultation				— Treating Comp
referral source				_

Treatment	given prior to this first vis	it at Sall/Myers:					
Date: Where: ER Dr. Office Hospital Clinic							
Name and Address of first Medical Provider post accident:							
Transported by: Car Ambulance Other							
Treatment Given: Examination Ace Bandage Medicated Cervical Collar Sutures to							
X-Rays/CT Scan (be very specific and get reports of results faxed stat to our office)							
Summarize	e all the treatment given to	the patient prior to TODA	Y:				
Does the pai "Unable to get a good ni	our quality of life at this time n make you: o work and earn an income" ghts sleep" "Unable to go to	"Unable to function as a full tip school" "Unable to particip	me homemaker" ""Unable to sloate in sports" "Other"	hare in childcare duties" "Unable to			
TIME LOS	FROM WORK (IF EMPLO	OYED) TO DATE:					
1 2 3 4 5 6 7 8 Medical (Co	-Mobid) Conditions: (Check al	I that apply) Dominate Ha	and Left Right Emphysema Seizure Hea	art Attack Ulcers Other:			
Cu	irrent Medications:		Prior Surgeries:	Prior Surgeries:			
PREVIOUS	ACCIDENTS AND/OR INJU	JRIES (Must list every injure	d area that patient has received	treatment)			
Year	MVA/ or Fall Down	Body Part Injured	MRI Done (Yes or No)	Was a lawsuit filed?			
				,			
Interviewed	by:	Spanish	English Other	Date			
E-Mail Patient's Sig		gnature	Date				