SALL/MYERS MEDICAL – INTAKE INFORMATION FOR TREATING PATIENTS

Last Name ______________________ First ______________________ Initial ________

Today's Date ______________________ Date of Accident ______________________

Home Address ____

Home Phone # ______________________ Work # ______________________

Social Security # ________________ Marital Status ____________ # Children ________

Date of Birth __________ HT ________ WT __________ AGE ________ SEX ______

Parent/Guardian (If less than 18) ______________________________

Highest Level of Schooling ______________________ What Country: ______________

Were you employed at the time of the accident? ________ Where: ______________

Describe your job: ____

Are you free to get treatment during the day? _________

Health Insurance: Carrier: ______________ Address: ______________________

Insured: ______________________ Secondary Insurance ______________________

Attach a copy of identification card for each insurer listed.

PIP Insurance: Does the patient own a car? ______ Does anyone in the patient's household own a car? ______

If someone in the household owns a car, name of the insured ______________________

Has the accident been reported? __________ When? ______________________

Patients Carrier ______________________ Insured: ______________________

Address: ____

Relationship to the patient: ______________________________

Policy # ______________________ Claim #: ______________________

Adjuster: ______________________ Phone: ______________ Fax #: ______________

Documentation required for all PIP Claims: (Copy all, front and back)

Insurance ID Card: ______________ Declaration Page: __________ Police Report: ______

Driver's License: ______________________ 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 ______________

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:

____

____

____

____

____

____

____

____

Injured Body Area:

1. ______________________
2. ______________________
3. ______________________
4. ______________________
5. ______________________
6. ______________________

Office:

☐ Paterson
☐ Irvington
☐ Hackensack
☐ New Brunswick
☐ Passaic
☐ Union City
☐

Social History:

Are you a smoker?

☐ Yes ☐ No

If yes, How often______________

Any Allergies to Medication?

☐ Yes ☐ No

If yes, please List______________

Specialty Requested:

☐ Orthopedist
☐ Neurologist
☐ Psychiatrist
☐ Physical Medicine & Rehab
☐ Internist

Report Type:

☐ New Patient
☐ Treating Comp
☐ Consultation
☐ Assumption of case from a referral source

Treatment given prior to this first visit 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 all the treatment given to the patient prior to TODAY:

____

____

____

Do you have any pain in any body part now that you did not have initially? __________ Where? ______________________________

Impact on your quality of life at this time: ______________________________

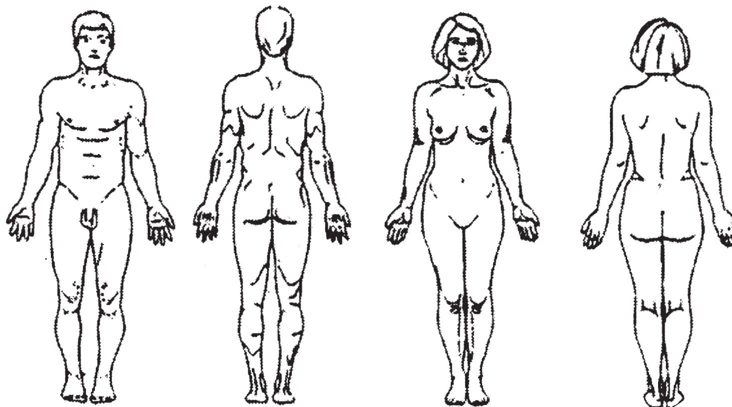
Does the pain make you:

☐ "Unable to work and earn an income" ☐ "Unable to function as a full time homemaker" ☐ "Unable to share in childcare duties" ☐ "Unable to get a good nights sleep" ☐ "Unable to go to school" ☐ "Unable to participate in sports" ☐ "Other" ______________________________

TIME LOST FROM WORK (IF EMPLOYED) TO DATE: ______________________________

Areas injured: (Indicate quality of pain on figure)

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________
5. ______________________________
6. ______________________________
7. ______________________________
8. ______________________________



Medical (Co-Mobid) Conditions: (Check all that apply) Dominate Hand ☐ Left ☐ Right

☐ None ☐ Asthma ☐ Stroke ☐ Diabetes ☐ Allergies ☐ Hypertension ☐ Emphysema ☐ Seizure ☐ Heart Attack ☐ Ulcers ☐ Other: ________

Current Medications:

____

____

____

____

Prior Surgeries:

____

____

____

____

PREVIOUS ACCIDENTS AND/OR INJURIES (Must list every injured 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 Signature ______________________________ Date ____________