WELCOME

Liringis Chiropractic
ACCIDENT & INJURY CENTER

Winston-Salem (336) 768-1004 • Fax (336) 659-1373
3570 Vest Mill Road,#B • Winston-Salem, NC 27103

NEW PATIENT REGISTRATION AND AUTO ACCIDENT QUESTIONNAIRE

Steve Liringis, DC
John Robinson, DC

1 ABOUT YOU

Today's Date: _____ / _____ / _____

Patient Name: _____
LAST FIRST MI

❑ Male ❑ Female

Birthdate: _____ / _____ / _____ Age: _____ SS#: _____

Mailing Address: _____

_____
CITY STATE ZIP

Home Phone #: _____ Cell Phone #: _____

Work Phone #: _____ Ext: _____

E-mail Address: _____

Employer: _____ How long? _____

Employer's Address: _____

_____
CITY STATE ZIP

Status: ❑ Minor ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed

Are you a full time student? ❑ Yes ❑ No

Do you reside with a relative? ❑ Yes ❑ No

Spouse's Name: _____

Do you have children? ❑ Yes ❑ No How many? _____

2 IN EVENT OF EMERGENCY

Whom should we contact? _____

Relationship: _____

Home Phone #: _____ Cell Phone #: _____

Work Phone #: _____ Ext: _____

Who is your medical doctor? _____

Medical doctor's phone #: _____

Staff Initials: _____

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3 QUESTIONS ABOUT ACCIDENT

1. Date of Accident: _____ Hour: _____ ❑ AM ❑ PM
   Specific location of accident? _____
2. Describe in detail, in your own words, how the accident happened? _____
_____
_____
_____
3. In the accident: Were you the ❑ Driver ❑ Passenger ❑ Pedestrian ❑ Other _____
4. Did your vehicle strike the other vehicle? ❑ Yes ❑ No
5. Did the other vehicle strike your car? ❑ Yes ❑ No
6. Were you struck from? ❑ Behind ❑ Front ❑ Driver Side ❑ Passenger Side
7. Were traffic citations issued to? ❑ You ❑ Driver of Your Vehicle ❑ Driver of the Other Vehicle ❑ No Citations Given
8. Were police at the scene? ❑ Yes ❑ No ❑ If Yes, was a report made? ❑ Yes ❑ No
9. Were you aware of impending crash? ❑ Yes ❑ No
10. Head Position at time of impact: ❑ Forward ❑ Left ❑ Right ❑ Up ❑ Down
11. Did your body hit anything? ❑ Yes ❑ No If Yes, describe: _____
_____
_____
12. Did air bag deploy? ❑ Yes ❑ No If yes, were you struck by air bag? ❑ Yes ❑ No Were you burned? ❑ Yes ❑ No
13. Were you wearing a hat or eye or sunglasses? ❑ Yes ❑ No If yes, were they still on after crash? ❑ Yes ❑ No
14. Did you lose consciousness? ❑ Yes ❑ No If Yes, for how long _____
15. **Estimated damage to the vehicle you were in? Amount of damage** _____
16. Your speed at time of accident _____
17. Road Conditions: ❑ Dry ❑ Damp ❑ Wet ❑ Snow ❑ Ice ❑ Other _____
18. **Was the at fault driver intoxicated or under the influence of drugs?** ❑ Yes ❑ No

4 HOSPITAL / EMERGENCY ROOM TREATMENT

1. Were you seen in the ER? ❑ Yes ❑ No
2. If Yes, which hospital? _____
3. Were you taken by ambulance? ❑ Yes ❑ No
4. Date seen if not taken by ambulance? _____
5. Was treatment given? ❑ Yes ❑ No If Yes, ❑ Injection ❑ Brace, ❑ Physical therapy ❑ Cane/Crutch
   ❑ Ice ❑ Medication: Name of Rx: _____
6. Other treatment? _____
7. Were x-rays taken? ❑ Yes ❑ No, If Yes, which body parts x-rayed _____
(If you have a report - please give to our staff - so copy can be made)
8. Lab work? ❑ Yes ❑ No Results: _____
9. Follow-up instructions: _____ ❑ None
10. **Did ER doctor write you out of work? ❑ Yes ❑ No If Yes, give dates** _____
11. **Did ER doctor write you a work restriction? ❑ Yes ❑ No If Yes, give dates** _____
12. Did you go back to the ER? ❑ Yes ❑ No If yes, which hospital: _____
13. Date you went back? _____

5 OTHER MEDICAL PROVIDERS OTHER THAN HOSPITAL/EMERGENCY ROOM

1. Is Liringis Chiropractic the only doctor's office you have been to for this accident? ❑ Yes ❑ No

If no, fill in the following:

Doctor: _____ Specialty: _____ Date first seen: _____

X-rays Made? If so, which area was taken _____

Currently treating? ❑ Yes ❑ No

Did a Doctor or Physican Assistant write you out of work? ❑ Yes ❑ No If Yes, give dates _____

Did a Doctor or Physican Assistant write you a work restriction? ❑ Yes ❑ No If Yes, give dates _____

Special test: _____ Referred to: _____

Doctor's Initials: _____
Staff Initials: _____

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6 AT FAULT (Person who caused the accident insurance company)

Adjuster handling your bodily injury claim: _____ **Claim #:** _____

If you do not know the claim number do you have their Policy Number: _____ _____

Adjuster Phone Number: _____ **Adjuster Fax Number:** _____

7 HEALTH HISTORY

1. **Do you have or have you had any of the following diseases, medical conditions or procedures?**

❑ Yes Tuberculosis	❑ Yes Thyroid Disease	❑ Yes Diabetes	❑ Yes Fainting/Seizures/Epilepsy
❑ Yes Kidney Disease	❑ Yes Gout	❑ Yes Hepatitis	❑ Yes Venereal Disease
❑ Yes Sciatica	❑ Yes Heart Disease/Heart Attack	❑ Yes Pollo/MS	❑ Yes Rheumatic Fever
❑ Yes Colon Disease	❑ Yes Heart Murmur	❑ Yes Bleeding	❑ Yes Sinus Problems
❑ Yes Paralysis	❑ Yes Congenital Heart Defect	❑ Yes Ulcers/Colitis	❑ Yes Frequent Neck Pain
❑ Yes Anemia	❑ Yes Heart Surgery/Pacemaker	❑ Yes Asthma	❑ Yes Lower Back Problems
❑ Yes Lung Disease	❑ Yes Transfusion	❑ Yes AIDS	❑ Yes Hepatitis
❑ Yes Stomach/Ulcer	❑ Yes Cancer	❑ Yes HIV	❑ Yes Glaucoma
❑ Yes Hi/Low Blood Pressure	❑ Yes Chemotherapy	❑ Yes ARC	❑ Yes Artificial Bone/Joint/Implants
❑ Yes Stroke	❑ Yes Arthritis	❑ Yes Shingles	
❑ Yes Seizures	❑ Yes Drug Dependence	❑ Yes Psychiatric Problems	

2. Please list any surgeries with dates and/or other serious medical condition(s) not listed above:

_____

3. List any past serious accidents with dates: _____
4. Please list anything that you may be allergic to: _____
5. List any family Health History: _____
6. Do you take supplements or vitamins? ❑ Yes ❑ No Do you exercise? ❑ Yes ❑ No _____ hours per week
7. Do you smoke? ❑ Yes ❑ No How much? _____ How long? _____
8. For women: Are you taking birth control? ❑ Yes ❑ No Are you nursing? ❑ Yes ❑ No
9. **Are you pregnant? ❑ Yes ❑ No If so, how many weeks?** _____

▲ We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.

▲ HIPAA Compliance - Our office is required by law to maintian the HIPAA Notice of Privacy Practices. This notice explains our legal duties and privacy practices with respect to your protected health insurance. Signature below acknowledges that I have read this Notice of our Privacy Practices. A copy will be provided to me upon request.

▲ I authorize the staff to perform any necessary medical services needed during diagnosis and treatment.

▲ I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Patient Signature: _____ Date: _____
Witness: _____ Date: _____
Staff Initials: _____

8 ATTORNEY INFORMATION (If Applicable)

1. Attorney Name: _____
Legal Assistant: _____
Address: _____
Phone: _____ **Fax:** _____

Doctor's Initials: _____
Staff Initials: _____