DALY INTEGRATED MEDICAL GROUP

CAD Injury History Form

General Information:

Patient' name: ____________________
Today's date: ____________________
Date of injury: ____________________
Marital status: ☐ M ☐ S ☐ W ☐ D
Habits:
Smoke: ☐ None Pk/day _____ Years ______
Alcohol: ☐ Never ☐ Social ☐ Light ☐ Mod. ☐ Heavy
Employment:
At time of crash: ____________________
☐ Unemployed
Currently: ____________________
☐ Unemplyed
Due to crash? ☐ Yes ☐ No
Type of work: ☐ Office/clerical ☐ Light labor ☐ Moderate labor ☐ Heavy labor

Past Medical History:

Surgeries (dates and residuals): ____________________

Fractures (dates and residuals): ____________________

Serious illness (dates and residuals): ____________________

Workers' comp. injuries (date, TX, awards, residuals): ____________________

Personal Injuries (date, TX, awards, residuals):

Sports or other injuries to head, neck, or back:

Any prior HX of current complaints:
1. ____________________
2. ____________________
3. ____________________

Prior TX by DC for these:
1. ____________________
2. ____________________
3. ____________________

Current Medical history:

Current health problems: ☐ None

Current medications taken: ☐ None

Injury History:

Was the crash on-the-job? ☐ Yes ☐ No
You were: ☐ Driver ☐ Front seat passenger ☐ Rear seat passenger ☐ Motorcycle operator ☐ Motorcycle passenger ☐ Other __________
Vehicle driven by: ____________________
Your vehicle (year, make, model): ____________________
Your estimated speed at moment of crash: __________
☐ Stopped ☐ Slowing ☐ Accelerating
Other vehicle (year, make, model): ____________________
Time of day: ☐ Daylight ☐ Dawn ☐ Dusk ☐ Dark
Road conditions: ☐ Dry ☐ Damp ☐ Wet ☐ Snow ☐ Ice ☐ Other __________
Head restraints: ☐ None ☐ Integral type ☐ Adjustable type: ☐ Up ☐ Down ☐ Don't know
If adjustable, was the position altered by the crash? ☐ Yes ☐ No
Was the seat back adjustment altered by the crash? ☐ Yes ☐ No
Was the seat broken? ☐ Yes ☐ No
Lap belt: ☐ Wearing ☐ Not wearing ☐ Don't know
Shoulder belt: ☐ None ☐ Wearing ☐ Not wearing ☐ Don't know
Did air bag deploy? ☐ Yes ☐ No
If yes, were you struck? ☐ Yes ☐ No
Body position: ☐ Good ☐ Forward lean
Other ____________________
Head position: ☐ Forward ☐ Left ____° ☐ Right ____° ☐ Up ____° ☐ Down ____°

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MEDICAL GROUP

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Injury History (cont.):

Hands: ☐ One on wheel ☐ Two on wheel ☐ N/A
Brakes applied? ☐ Yes ☐ No
Crash description: ____________________

Crash diagram:

Aware of impending crash? ☐ Yes ☐ No

During the crash:

Did you strike any parts of the vehicle? ☐ Y ☐ N
If yes, describe____________________
Did vehicle strike any objects after crash?
If yes, describe____________________
Wearing hat or glasses? ☐ Yes ☐ No
If yes, still on after crash? ☐ Yes ☐ No
Did you lose consciousness? ☐ Yes ☐ No
If yes, for how long?____________________
Estimated property damage to your vehicle:
$ ____________________
Estimated damage to other vehicle(s): ☐ None ☐ Minimal ☐ Moderate ☐ Major
Were the police on-scene? ☐ Yes ☐ No
If yes, was a report made? ☐ Yes ☐ No

After the crash:

Symptoms: ☐ Headache ☐ Dizziness ☐ Nausea ☐ Confusion/disorientation ☐ Neck pain ☐ Paresthesia(s)
If yes, where?____________________
☐ Extremity pain. If yes, where?____________________
☐ Back pain
When did SX first appear? ☐ Immediately
(describe which SX)__________ hr afterward
Where did you go after crash? ☐ Home ☐ Work ☐ Hospital:
Mode of transportation ____________________
Pvt. doctor:____________________

Emergency department:

Radiographs: ☐ Yes ☐ No
Body parts imaged____________________
Results____________________
Lab work ☐ Yes ☐ No ____________________
☐ Cervical collar ☐ Ice
Medications:____________________
Other: ____________________
Follow-up instructions: ☐ None____________________

Treatment history:

Dr.: ____________________
Specialty:__________ Date first seen: __________
Referred by:__________TX type: __________
TX frequency:__________TX duration: __________
Currently treating? ☐ Yes ☐ No
Any disability? ☐ Yes ☐ No
If yes, describe:____________________
Special tests:____________________
Referred to:____________________
Did TX help? ☐ Yes ☐ No
Notes: ____________________

I agree that the above statement is the most accurate record of the vehicle accident in question. I understand this will be used to evaluate for possible cervical acceleration/ deceleration syndrome and related conditions.

____
Patient Signature

____
Date

Standard Disclosure and Acknowledgement Form
Personal Injury Protection - Initial Treatment or Service Provided

The undersigned insured person (or guardian of such person) affirms:

1. The services or treatment set forth below were **actually rendered.** This means that those services have **already been provided.**

____

____

2. I have the right and the **duty to confirm** that the services have already been provided.
3. I was **not solicited** by any person to seek any services from the medical provider of the services described above.
4. The medical provider has **explained** the services to me for which payment is being claimed.
5. If I notify the insurer in writing of a billing error, I may be entitled to a portion of any reduction in the amounts paid by my motor vehicle insurer. If entitled, my share would be at least 20% of the amount of the reduction, up to $500.

Insured Person (patient receiving treatment or services) or Guardian of Insured Person:

______________________	______________________	______________
Name *(PRINT or TYPE)*	Signature	Date

The undersigned licensed medical professional or medical director, if applicable, affirms the statement numbered 1 above and also:

A. I have **not solicited** or caused the insured person, who was involved in a motor vehicle accident, to be solicited to make a claim for Personal Injury Protection benefits.

B. The treatment or services rendered were explained to the insured person, or his or her guardian, **sufficiently** for that person to sign this form with informed consent.

C. The accompanying statement or bill is **properly completed** in all material provisions and all relevant information has been provided therein. This means that each request for information has been responded to **truthfully, accurately**, and in a **substantially complete** manner.

D. The coding of procedures on the accompanying statement or bill is proper. This means that **no service has been upcoded, unbundled**, or constitutes an invalid **or not medically necessary diagnostic test** as defined by Section 627.732(14) and (15), Florida Statutes or Section 627.736(5)(b)6, Florida Statutes.

Licensed Medical Professional Rendering Treatment/Services or Medical Director, if applicable *(Signature by his/ her **own hand**):*

______________________	______________________	______________
Name *(PRINT or TYPE)*	Signature	Date

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of Claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree per Section 817.234(1)(b), Florida Statutes.

Note: The **original** of this form must be furnished to the insurer pursuant to Section 627.736(4)(b), Florida Statutes and may **not** be electronically furnished. Failure to furnish this form may result in non-payment of the claim.