Blue Q Health & Wellness

AUTOMOBILE ACCIDENT PAPERWORK

Name:_____ Today's Date:_____

Address:_____ City/State/Zip:_____

Phone:_____ Date of birth: _____

Insurance:_____ Medical Claim #: _____

Adjustor Name and Phone Number:_____

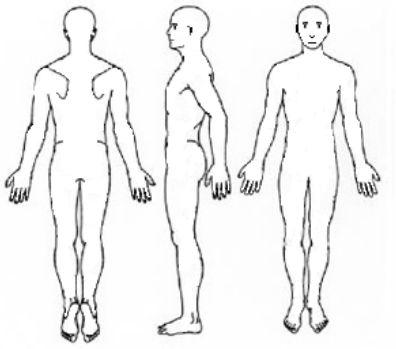
Date of Accident:_____

Main Complaint: _____

Pre-existing Complaints made worse by accident:_____

New Complaints: _____

Area(s) of complaint (circle on diagram); Please describe in the blank space to the right of the diagram:



Stiffness Soreness Numbness Tingling Weakness Swelling Dull Achy Sharp Stabbing Burning

If you are experiencing pain, please circle a number: (No Pain) 0-1-2-3-4-5-6-7-8-9-10 (Severe)

Did you go to the hospital/doctor? Y or N: (Name of Hospital/Office if Yes) _____

Were you the driver? Y or N Time of Day: AM or PM

Road Conditions: Wet Dry Normal Construction

Wearing your seat Belt? Y or N Did airbags deploy? Y or N

Did any part of you strike the inside of the car? Y or N _____

Was there a secondary collision (after the initial impact, your car hit another car or object) Y or N

2480 E. Bay Dr. #13, Largo, FL 33771
727-530-7778

Please explain what happened leading up to the time of the accident, time of accident, immediately after accident, and leading up to your visit today:

_____
_____
_____
_____
_____
_____
_____
_____
_____

Receipt of Notice of Privacy Practices Written Acknowledgement Form

I understand that my health information will remain private and will not be shared with anyone without my written or verbal approval. I have received a copy of Blue Q Health and Wellness PLLC Notice of Privacy Practices. I understand that Blue Q Health and Wellness PLLC has the right to change its Notice of Privacy Practices from time to time and that I may contact Blue Q Health and Wellness PLLC at any time to obtain a current copy of the Notice of Privacy Practices. I authorize the sharing of my health information with the following party or parties listed below:

_____

(List any names of lawyers, doctors, or family members who may contact us for your health information)

ASSIGNMENT OF BENEFITS

I, _____, assign all of the rights and benefits of any applicable health insurance policies, personal injury protection, medical payments, or other coverage provided by any insurance policy issued pursuant to Florida Statutes §627.730 - §627.7405, to Erika Meister DC at Blue Q Health and Wellness PLLC or other provider, for services and supplies provided to me. I agree to pay any co-payment or deductible not covered by the applicable health insurance policy, personal injury protection, medical payments, or other insurance coverage.
This assignment includes, but is not limited to:

- all rights to collect benefits directly from any insurance carrier obligated to provide
- benefits for services and supplies I have received;
- all rights to take legal or other action against any insurance carrier obligated to provide
- benefits if for any reason the insurance carrier fails to pay any benefits due; and
- all rights to recover attorney fees, legal assistant fees, costs, and any interest on fees
- and costs, for any legal or other action taken by Blue Q Health and Wellness PLLC as my assignee.

This is an assignment of rights only, and is not a delegation of any of my duties under the subject insurance policy. I agree that Blue Q Health and Wellness PLLC or health provider may retain any attorney it chooses to bring legal action against any insurance carrier obligated to provide benefits for services and supplies I have received, and that the attorney chosen may be different than any attorney I may have handling any claim I may have for personal injuries. I have been given a copy of this assignment to retain for my records; I have read this assignment and I am satisfied that I fully understand the purpose and implications of executing this assignment and do so freely and voluntarily.

_____ _____
Patient Name (or Guardian) Date

_____ _____
Representative of Blue Q Health and Wellness Date

Have you been hospitalized last 5 yrs? N or Y **(explain)**

_____

Have you had Surgery last 5 yrs? N or Y **(explain)**

_____

Have you had a serious Accident/Injury last 5 yrs (OTHER THAN CURRENT ACCIDENT)? N or Y **(explain) _____**

Do you have any Allergies? N or Y **(list)**

_____

Are you currently taking any Medication? N or Y **(list)_____**

WOMEN ONLY:
Are you currently pregnant? Y or N (Yes, due date: _____) Date of Last Physical Exam: _____
Where? _____

***REVIEW OF SYMPTOMS*: Which of the following conditions do you now have or previously had?** (circle)

Arthritis	Asthma	Sinus Issues	Blood Clotts	Allergies
Tuberculosis	Diabetes	Vertigo	ADD/ADHD	Epilepsy
Migraine/HA's	Thyroid	High BP	Low BP	Heart Trouble
Pacemaker	HIV/AIDS	Cancer	Polio	Scoliosis
Mental/Emotional		Prostate Trouble	Hormonal	Dislocation
Disc Herniation/Bulge		Rheumatic Fever	Bone Fracture	Osteoporosis **NONE**
Kidney Disease		Digestive Trouble	Acid Reflux	Sleep Disorder

Family History:

	Cancer	Diabetes	Blood Pressure	Heart Attack	Stroke	Osteoporosis	Arthritis	Scoliosis	Other
Father									
Mother									
Sibling (s)									
Child/Children									
Grandparent(s)									

Blue Q Health & Wellness

CHIROPRACTIC

Name:_____ DOB: _____ Today's Date:_____

Medical History:

Have you been to a Chiropractor? N or **Y** (Date of last visit: _____)

Name/Location/ Phone: _____

Type of Chiropractic Care and outcome: _____

Questions/Comments/Concerns:

_____

_____

_____

Goals of Treatment:

_____

_____

_____

_____

I hereby request and consent to the performance of a chiropractic evaluation and treatment (for myself or for a minor) by Dr. Erika Meister (chiropractor) or other licensed health provider at Blue Q Health and Wellness. I will have the opportunity to discuss with the doctor and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed. I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, dislocations, and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts known to her, is in my best interest. I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient Signature_____ Date _____

Doctor Signature _____ Date _____

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