

KAPSNER CHIROPRACTIC CENTERS

Patient Personal Injury & Financial Information

Name _____ Date of Birth _____
Address _____
City _____ State _____ Zip Code _____
Home # _____ Cell # _____
Driver's License # _____
Social Security # _____

E-mail Address _____

Employer _____
Employer Address _____
Occupation _____
Work # _____
Spouse Name _____ Phone # of Spouse _____
Name of Nearest Relative or Friend _____ Relationship _____
Relative/Friend's Phone # _____

Financial Information

Personal Injury Protection (Your Policy): This is insurance that is not required by the state of Texas, but most owners carry on their policy. It may be used to cover medical expenses, or to cover a percentage of lost wages. You have the right to use it even if you were not at fault.

Company Name _____ Adjuster _____
Address _____ Phone # _____
Name of Insured _____ Date of Birth _____
Policy # _____ Claim # _____

Party at Fault Insurance Information:

Company Name _____ Adjuster _____
Address _____ Phone # _____
Name of Insured _____ Date of Birth _____
Policy # _____ Claim # _____

General Health Insurance:

Company Name _____
Name of Insured _____ Date of Birth _____
Policy # _____ Group # _____

Signature _____ Date _____

Kapsner Chiropractic Centers

Personal Injury History Form

Patient's Name: _____

Today's Date: _____

Date of Injury: _____

Type of Work: Office/Clerical Light Labor Mod Labor Heavy Labor

Injury History: General

Was the crash on the job? Yes No

You were: Driver Front-passenger Rear passenger

Vehicle driven by: _____

Vehicle you occupied (year, make, model): _____

Time of Day: Daylight Dawn Dusk Dark

Road conditions: Dry Wet Other: _____

Headrest: None Up Down

If adjustable, was the position altered by crash? Yes No

Was the seat back adjustment altered by crash? Yes No

Was the seat broken? Yes No

Seat belt: 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

Hands: One on wheel Two on Wheel N/A

Brakes Applied? Yes No

Crash Description: _____

During the Crash:

Were you aware of the impending crash? Yes No

Did you strike any parts of the vehicle? Yes No

If yes, describe: _____

Did vehicle strike any objects after crash? Yes No

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 damage to the vehicle you occupied None

Minimal Moderate Major

Estimated damage to other vehicle(s): None Minimal

Moderate Major

Police on-scene? Yes No Report made? Yes No

Were there other passengers in your vehicle? Yes No

After the Crash:

Symptoms:

Headache Dizziness Nausea

Confusion

Neck Pain

Back Pain

Numbness/tingling: where _____

Extremity Pain If so, where? _____

When did symptoms appear? Immediately hours afterwards other _____

Where did you go after crash? Hospital Home Work

Pvt. Doctor: _____

Mode of transportation getting there: _____

Emergency Department:

Hospital Name: _____

Radiographs (X-rays, MRI, etc) taken? Yes No

Body parts imaged: _____

Results: _____

Treatment issued: Cervical Collar Ice Other: _____

Medications: _____

Follow-up Instructions: None Other: _____

Treatment History

Dr: _____

Specialty: _____ Date first seen: _____

Treatment type: _____

Treatment Frequency: _____

Treatment Duration: _____

Currently treating? Yes No

Referred to: _____

Did the treatment help? Yes No

Notes:

I understand and agree that health insurance and auto accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I clearly understand and agree that all services rendered me are charged directly to me and that I am responsible for payment. I allow this office to endorse co-issued remittances for the conveyance of credit to my account. I also authorize my auto insurance or the at fault person's auto insurance company to pay Kapsner Chiropractic Centers directly from any settlement payment.

Patient's Signature

Date

Guardian's Signature

Date

KAPSNER CHIROPRACTIC CENTERS

Accident/Injury Questionnaire

Name _____ Date _____

Check any of the following that you have experienced since, and/or as a direct result of this accident or injury. Please add comments accordingly.

- | | |
|---|---|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> TMJ (jaw) Pain or Discomfort |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Numbness or Tingling |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Loss of Consciousness |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Loss of Memory |
| <input type="checkbox"/> Visual Disturbance | <input type="checkbox"/> Contusions (black/blue) |
| <input type="checkbox"/> Trouble Sleeping | |

Have you had difficulty with any of the following:

- | | |
|--|----------------------------------|
| <input type="checkbox"/> Housework | <input type="checkbox"/> Walking |
| <input type="checkbox"/> Lawn or Garden Activities | <input type="checkbox"/> Hobbies |
| <input type="checkbox"/> Exercise Routine | <input type="checkbox"/> Sports |
| <input type="checkbox"/> Standing | <input type="checkbox"/> Sitting |

Due to this injury/accident, have you undergone any of the following:

- Medications
- Injections
- Surgery
- Ambulance
- Hospital/Emergency Room
- Supports/Casts/Collars/Braces
- Medical Doctor Treatment or Evaluation - Doctor's Name _____
- Off Work Please List Dates _____

At the time of this accident/injury:

- Were you wearing a seatbelt?
- Were you braced, prepared, and or anticipating the accident?
- Did you strike your head or face?
- Were the road conditions icy or wet?
- Did your seat, seatback, or seatbelt break or get damaged?
- Did your airbag deploy?

Describe your body position at the time of the accident:

KAPSNER CHIROPRACTIC CENTERS

Name _____

Date _____

Nombre _____

Fecha _____

PAIN DRAWING DIBUJO DE DOLOR

MARK WHERE YOU HAVE PAIN OR ALTERED SENSATION
MARQUE DONDE SIENTA DOLOR O SENSACION ALTERADA

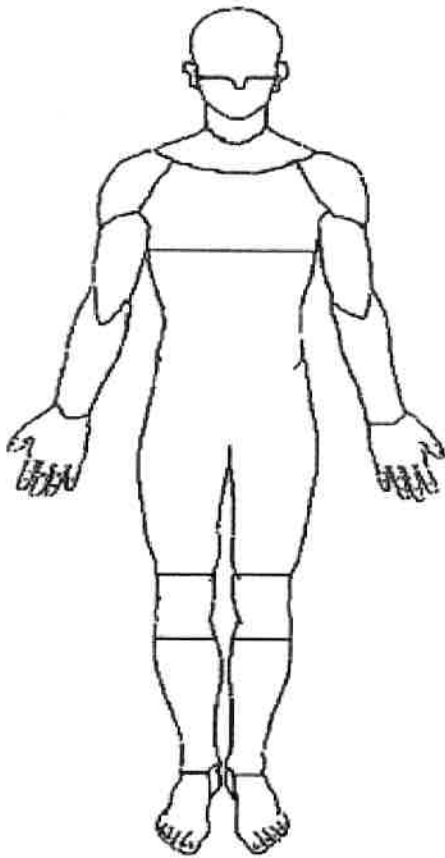
Pain
Dolor

Tingling
Hormigueo

Burning
Ardor

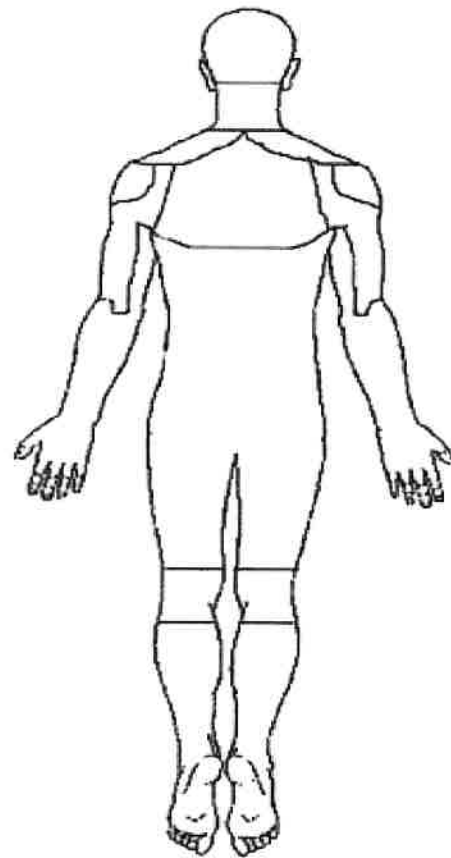
Numbness
Adormecimiento

Stiffness
Tiedadad



Front

Enfrente



Back

Atras

Dr. Michael A. Kapsner, D.C.
 Dr. Michael J. Snow, D.C.
 Dr. James R. Schiffer, D.C.
 Dr. Christopher Curry, D.C.
 Dr. Jay A. Heath, D.C.
 Dr. Dylan J. Payne, D.C.

INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENTS AND CARE

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me (or the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working, or associated with or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic.

I have had an opportunity to discuss with the doctor of chiropractic named below 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 in treatment, including, but not limited to, fractures, disc injuries, strokes, 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 on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, 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(s) and for any future condition(s) for which I seek treatment.

To be completed by patient or patient's representative, if necessary (e.g., if patient is a minor or is physically or mentally incapacitated):

Print Patient's Name	Patient's Signature	Date
Print name of patient's representative	Signature and relationship of patient's representative	

SOUTH AUSTIN:	1701 W Ben White Blvd. Ste. 160 • Austin, TX 78704	(512) 441-1240 • Fax (512) 441-3762
NORTH AUSTIN:	8440 Burnet Rd., Ste. 118 • Austin, TX 78757	(512) 459-4014 • Fax (512) 459-4017
ROUND ROCK:	2000 S. IH 35, Ste. H-1 • Round Rock, TX 78681	(512) 733-1700 • Fax (512) 733-1713
CEDAR PARK:	401 E. Whitestone Blvd. C-104 • Cedar Park, TX 78613	(512) 260-4020 • Fax (512) 260-4185
BASTROP:	1106 College Street, Ste. A • Bastrop, TX 78602	(512) 985-5486 • Fax (512) 985-5477

KAPSNER CHIROPRACTIC CENTERS

Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name: _____

I hereby acknowledge that upon request, a copy of Kapsner Chiropractic Centers Notice of Privacy Practices is available to me. I understand that I have the right to refuse to sign this acknowledgement if I so choose.

Signature of Patient or Legal Representative

Date

Printed Name of Patient's Representative (if applicable)

- Parent or guardian of minor
- Court appointed guardian
- Executor or administrator of descendant's estate
- Power Of Attorney

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices on the following date, _____ but acknowledgement could not be obtained because:

- Patient/Representative refused to sign
- Emergency situation prevented us from obtaining acknowledgement at this time (Will attempt again at a later date)
- Communication barriers prohibited obtaining acknowledgement (Explain)

- Other (Specify)

