Precision Injury Care

555 Old Norcross Rd Suite 210, Lawrenceville GA 30046
2300 Camp Creek Pkwy Suite 200, Atlanta GA 30037
997 Commerce Dr. Suite 1A Conyers, GA 30094
Phone: 678-666-4088 Fax: 678-666-4033

NEW PATIENT INTAKE FORM

Please complete all sections thoroughly. All information is confidential.

SECTION A — PATIENT DEMOGRAPHICS

First Name		**Last Name**		**Date**	
Date of Birth		**Age**		**Sex**	☐ Male ☐ Female
Address				**City**	
State		**Zip**		**Email**	
Home Phone		**Cell Phone**		**Preferred Contact**	☐ Phone ☐ Text ☐ Email
Emergency Contact		**Relationship**		**Phone**	
Employed?	☐ Yes ☐ No	**Able to Work?**	☐ Yes ☐ No	**Days Missed Since Accident**	
Attorney?	☐ Yes ☐ No	**Law Firm Name**		**Phone**	

SECTION B — INSURANCE INFORMATION

Health Insurance?	☐ Yes ☐ No *If yes, list name & policy #*	**Insurance Name**		**Policy Number**	
Auto Insurance		**Claim Number**		**MedPay Limit (if applicable)**	
Adjuster Name (if applicable)					

SECTION C — ACCIDENT / INCIDENT INFORMATION

Date of Accident		**Police Called?**	☐ Yes ☐ No		
Type	☐ Auto ☐ Motorcycle ☐ Pedestrian ☐ Slip/Fall ☐ Workplace ☐ Other: _____				
Position	☐ Driver ☐ Front Passenger ☐ Rear Passenger ☐ Pedestrian ☐ Other: _____				
Airbag Deployed?	☐ Yes ☐ No	**EMS Called?**	☐ Yes ☐ No	**Go to Hospital?**	☐ Yes ☐ No
What hospital did you go to?		**Did you have MRIs/CT**	☐ Yes ☐ No		
Accident Description					

SECTION D — TREATMENT FOR THIS INJURY

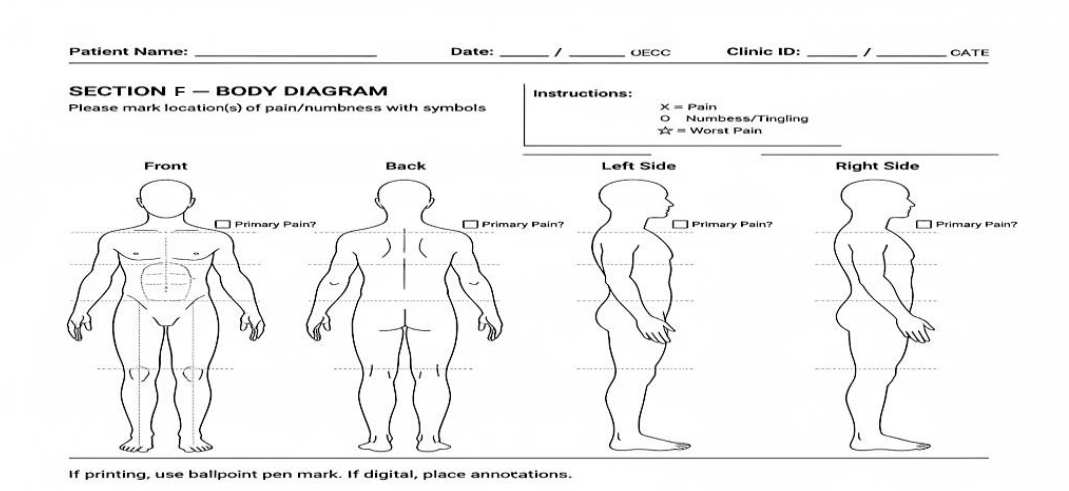
Immediate Care After Accident?	☐ Yes ☐ No	**Facility/Type**		**Date(s)**	
Treated Elsewhere for Same Injury?	☐ Yes ☐ No	**Where / When**			
Treatments Received	☐ Physical Therapy ☐ Chiropractic ☐ Injection ☐ Rx Medications ☐ Other: _____				

SECTION E — CURRENT SYMPTOMS & PAIN

Symptoms (check all)	☐ Neck ☐ Upper Back ☐ Mid Back ☐ Low Back ☐ Shoulder ☐ Arm/Hand ☐ Hip/Leg ☐ Ankle/Foot ☐ Headache ☐ Numbness/Tingling ☐ Dizziness ☐ Chest/Abd Pain ☐ Other: _____
When Did your Problem Start? (Explain)	
Pain Scale (0–10)	Neck: ___ Mid Back: ___ Low Back: ___ R Shoulder: ___ L Shoulder: ___ R Arm/Leg: ___ L Arm/Leg: ___ Headache: ___ Other: _____
Functional Impact	☐ Unable to Work ☐ Driving Difficulty ☐ Sleep Trouble ☐ Limited ROM ☐ Daily Activity Limits ☐ Other: _____

SECTION F — BODY DIAGRAM

Number symptoms 1–10 (1 = most severe). Mark: X = Pain O = Numbness / = Weakness ★ = Worst Area



SECTION G — MEDICAL HISTORY & MEDICATIONS

Height		**Weight**	
Do you have a Primary Care Physician?	☐ Yes ☐ No	**If Yes, Who is your Primary Care Physician?**	Name _____ Phone Number _____ Address_____
Major Surgeries			

Current Medications:

1	Medication Name		**Dose**		**Freq/day**		**Prescribed By**	
2	Medication Name		**Dose**		**Freq/day**		**Prescribed By**	
3	Medication Name		**Dose**		**Freq/day**		**Prescribed By**	
4	Medication Name		**Dose**		**Freq/day**		**Prescribed By**	
5	Medication Name		**Dose**		**Freq/day**		**Prescribed By**	

OTC Medications Currently Taking:

Allergies (Medical, Food, Environmental):

Medical History — Check all that apply:

☐ AIDS	☐ Alcoholism	☐ Allergies	☐ Anemia
☐ Appendicitis	☐ Arthritis	☐ Asthma	☐ Bleeding Disorders
☐ Bronchitis	☐ Cancer	☐ Chest Pain	☐ Heart Disease
☐ Diabetes	☐ Epilepsy	☐ Eating Disorders	☐ Fractures
☐ Hepatitis	☐ Herniated Disc	☐ Herpes	☐ High Cholesterol
☐ Kidney Disease	☐ Liver Disease	☐ Lung Disease	☐ Measles
☐ Migraines	☐ Miscarriage	☐ Osteoporosis	☐ Pacemaker
☐ Parkinson's Disease	☐ Pinched Nerve	☐ Pneumonia	☐ Polio
☐ Prostate Problems	☐ Psychiatric Care	☐ Rheumatoid Arthritis	☐ Stroke
☐ STD's	☐ Suicide Attempt	☐ Thyroid Issues	☐ Tuberculosis
☐ Tumors/Growths	☐ Typhoid Fever	☐ Ulcers	☐ Other: _____

SECTION H — CONSENT & SIGNATURE

I certify that the above information has been answered accurately and to the best of my knowledge. I authorize release of information necessary for treatment and/or insurance claims, and assignment of benefits.

Patient/Guardian Signature		**Date**	
Witness Signature		**Date**	
Printed Name (if not patient)		**Relationship**	

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Medical Records Request

Date: _____

To: _____

_____ hereby requests that my complete medical records be released to Precision Injury Care.

> I understand that this authorization allows the release of all information in my medical records to include lab test results, x-rays, and any surgery information. This authorization allows such records to be mailed or faxed. I understand that I may revoke this consent at any time. This consent will automatically expire without my expressed revocation **90 days** from the date on this form.

Patient Name: _____

Patient Address: _____

Patient DOB: _____

Patient / Guardian Signature: _____

Mailing Address
2133 Hwy 317 #12-345 | Suwanee, GA 30024

Precision Injury Care: Lawrenceville/Camp Creek/Conyers, GA
Rivermead Post Concussion Symptoms Questionnaire

Name: DOL: Date:

After a head injury or accident some people experience symptoms that can cause worry or nuisance. We would like to know if you now suffer any of the symptoms given below. Because many of these symptoms occur normally, we would like you to compare yourself now with before the accident. For each symptom listed below please circle the number that most closely represents your answer.

0 = not experienced at all
1 = no more of a problem
2 = a mild problem
3 = a moderate problem
4 = a severe problem

Compared with before the accident, do you **now** (i.e., over the last 24 hours) suffer from:

	Not Experienced	No more of a problem	Mild problem	Moderate problem	Severe problem
Headaches	0	1	2	3	4
Feelings of dizziness	0	1	2	3	4
Nausea and/or vomiting	0	1	2	3	4
Sleep disturbance	0	1	2	3	4
Fatigue, tiring more easily	0	1	2	3	4
Being irritable, easily angered	0	1	2	3	4
Feeling depressed or tearful	0	1	2	3	4
Feeling frustrated or impatient	0	1	2	3	4
Forgetfulness, poor memory	0	1	2	3	4
Poor concentration	0	1	2	3	4
Taking longer to think	0	1	2	3	4
Blurred vision	0	1	2	3	4
Light sensitivity (easily upset by bright light)	0	1	2	3	4
Double vision	0	1	2	3	4
Restlessness	0	1	2	3	4

Are you experiencing any other difficulties? Please specify and rate as above.

1.	0	1	2	3	4
2.	0	1	2	3	4

Administration only:

RPQ-3 *(total for first three items)*
RPQ-13 *(total for next 13 items)*

Precision Injury Care

AUTHORIZATIONS & RELEASES / FINANCIAL POLICY / LIEN FOR MEDICAL SERVICES

Patient _____ Date of Loss/Injury _____ Attorney _____

_____ Initial **Consent for Treatment**

I, the undersigned, hereby authorize the doctors of Precision Injury Care and whomever they may designate as their assistant(s) to perform evaluations, diagnostic tests and to administer treatment as is necessary. I also certify that no guarantee or assurance has been made as to the results that may occur as a result of this treatment.

_____ Initial **Consent for Treatment of Minor**

I, the undersigned, hereby authorize the doctors of Precision Injury Care and whomever they may designate as their assistant(s) to perform evaluations, diagnostic tests and to administer treatment as is necessary to my child (Child's Name) _____, of whom I am the legal guardian.

_____ Initial **Certification, Authorization and Release in Accordance with HIPAA**

I authorize the release of any medical information necessary to process my insurance claim(s) and also certify that all insurance and accident information given by me to Precision Injury Care is correct and complete. I understand that my medical information relating to this personal injury case may be shared to manage and expedite my medical treatment. I authorize my treating physician(s) and Precision Injury Care to secure, release and disclose medical treatment information only with companies, individuals, and any necessary parties involved in my case.

_____ Initial **Request for Payment of Benefits to Provider of Care**

I hereby authorize my insurance company/insurance administrator to pay by check, mailed directly to Precision Injury Care, any benefits allowable and otherwise payable to me under my current policy, as payment toward the total charges for professional services rendered. I understand that Precision Injury Care is a separate and distinct medical provider, and my attorney and/or insurance company will receive separate bills and statements for services provided by the doctors of Precision Injury Care or their assistant(s).

_____ Initial **Attorney Representation and Protection of Balance**

I authorize and direct my attorney, _____, to pay directly to Precision Injury Care for services rendered to me and/or my children and to withhold such sums from my portion of any settlement, claim, judgment or jury verdict. I fully understand that I am responsible for all medical bills and that this agreement is made in consideration of Precision Injury Care's agreement to forgo immediate payment, by me, for such medical services at the time those services were rendered. I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee.

_____ Initial **Payment Policy**

Precision Injury Care expects to be paid by the first available means, whether by health insurance, your Auto Medical Payments, or settlement of your case. It is the policy of Precision Injury Care to file all available applicable insurance on an accidental injury patient, including:

Health Insurance: Proof of insurance must be provided in order for us to file claims with your insurance company. Please understand that benefits through health insurance policies differ. Insurance companies pay according to your individual policy limits. Benefits are between you and your insurance carrier. Any discrepancies with your benefit coverage must be handled by you and your insurance provider. Any portion of your medical bills that is not covered by your insurance will be included in your statement sent to your attorney and paid once your case settles.

Auto Insurance: Precision Injury Care does not file against the third-party insurance. If there is MED PAY on your policy or on the policy of the car you were a passenger in, Precision Injury Care will submit to that carrier. If there are medical benefits available, there may be a maximum allowable amount of coverage, which may not cover all charges in full. Any portion of your medical bills that is not covered by your health insurance or Med Pay coverage will be included in your statement sent to your attorney and paid once your case settles.

I understand, agree to and will abide by all of the above. I will cooperate in processing this accident claim. I fully understand and acknowledge that I am responsible for all medical charges incurred by me for services provided by Precision Injury Care.

PATIENT NAME	PATIENT SIGNATURE	DATE
ATTORNEY NAME	ATTORNEY SIGNATURE	DATE

WITNESS _____

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