Dema Rehab & Injury Clinic Inc.

Orlando Location:

7758 Wallace Rd, Suite A&B, Orlando, Fl 32819

Tel (407)352-5882 , Fax: (407)352-5883

Kissimmee Location:

2928 Vineland Rd, Kissimmee, Fl 34746

Tel (407)344-4242 , Fax: (407)507-0063

REPORT OF HISTORY FOR PERSONAL INJURY

VITAL HISTORY

Name:_________________________________Phone________________date______________________________

Address:____

Your Social Security #:____________________________Birth date:____________________________________

E-mail Address:____

Ht.:__________WT.:___________ Marital Status____________________________

Occupation:______________________Employed by:_____________________Phone: ____________________

Regular Health Insurance:____________________ Secondary:______________________________________

AUTO INSURANCE

Your Auto Insurance Co.:_________________Claim #_______________

Name on Policy (if other than self):____________________________Policy #: ___________________________

ATTORNEY

Name:____Phone: _______________________________

Address: ____

NATURE OF ACCIDENT

1. Date of Accident_________________________________Time of __________________________________

2. Were you: □ Driver □ Passenger □ Front Seat □ Back Seat

3. Number of people in your vehicle?_____________Were you wearing seat belts? _______________________

4. Were you struck from: □ Behind □ Front □ Left side □ Right side

5. Approximate speed of your car____________mph Other car____________mph

6. Were you knocked unconscious? □ Yes □ No If yes, for how long?___________________________

7. Were police notified? □ Yes □ No

8. In your own words, please describe accident:____

____

____

____

Before the accident

9. Have you been hospitalized in the last 5 years? □ No □ Yes> If yes, for what?________________________

Have you had major surgery in the last 5 years? □ No □ Yes > If yes, what surgery?___________________

10. Do you have any congenital (from birth) factors of which you are aware? □ Yes □ No If yes, please describe:

11. Do you have any previous illnesses of which you are aware? □ Yes □ No If yes, please describe:

____

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12. Have you ever been involved in an accident before? □ Yes □ No If yes, please describe, including date(s) and type(s) of accidents, as well as injury(ies) received ____

13. Did you have any physical complaints **BEFORE THE ACCIDENT**? □ Yes □ No If yes, please describe in detail:
____
____

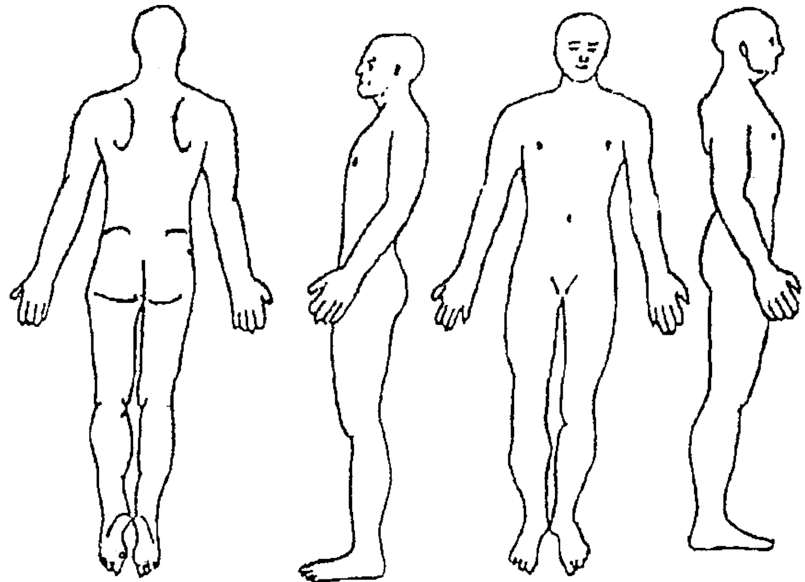
After the accident

14.CHECK SYMPTOMS YOU HAVE NOTICED SINCE THE ACCIDENT:

□ Headache	□ Irritability	□ Numbness in Toes	□ Loss of Balance	□ Jaw pain
□ Neck Pain	□ Chest Pain	□ Shortness of Breath	□ Left Soulder pain	□ TMJ pain
□ Neck Stiff	□ Dizziness	□ Fatigue	□ Right Shoulder pain	□ Elbow/Arm pain
□ Sleeping Problems	□ Head Seems Too Heavy	□ Depression	□ Left Knee pain	□ Bruising
□ Back Pain	□ Pins & Needles in Arms	□ Lights Bother Eyes	□ Right Knee pain	
□ Nervousness	□ Pins & Needles in Legs	□ Loss of Memory	□ Foot /Ankle Pain	
□ Tension	□ Numbness in Fingers	□ Ears Ring	□ Wrist / Hand pain	

Symptoms Other Than Above : ____

Mark the areas on your body where you feel pain or numbness/ tingling



____

15 Where were you taken after the accident? ____

16. Have you been treated by another doctor since the accident? □ Yes □ No If yes, please list doctor's name and address:____

What type of treatment did you receive?____
____

Have you ever seen a chiropractor before? □ Yes □ No If yes, doctor's name:________________________

17. Since this injury occurred, are your symptoms: □ Improving □ Getting Worse □ Sa me

18. Have you lost time from work as a result of this accident? □ Yes □ No

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19. Do you notice any activity restrictions as a result of this injury? ☐ Yes ☐ No If yes, please describe, in detail:
____
____

20. Other pertinent information:____
____

INSURANCE PATIENTS

Our office does not guarantee that your insurance will pay. We will make every effort, at the beginning of your health care, to receive verification of your policy and it's benefits. However, if for some reason, your insurance claim is denied, you are responsible for the full amount of your bill.

I Authorize the Release of any Medical Information Necessary to Process the Claim.

I authorize payment of medical benefits TO **DEMA REHAB & INJURY CLINIC** for services rendered

SIGNED (Insured or Authorized Person)____ Date______________________________

Consent To Treatment of Minor Child

I hereby authorize **Dr. Ouadi Hassine** and whomever he may designate as his assistants to administer chiropractic care as he deems necessary to my _____________ _________________(indicate relationship of child). Name_____
____

Signed____
Parent of Guardian

DATE:____________________________

Witness: ____

Pregnancy Release

DATE:____________________________

I,______________________________________in signing this form, state to the best of my knowledge there is no pregnancy (confirmed or suspected) at the time this service was rendered.

Patient's Signature ____________________________________

DATE:____________________________

Witness____

I hereby certify that the enclosed information is true and answered correctly. I give my consent for examination, x-rays and treatment at the office of Dema Rehab & Injury Clinic.

Patient Signature____Date _____________________

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PATIENT MEDICAL HISTORY

PLACE MARK ON 'YES' OR 'NO' TO INDICATE IF YOU HAVE HAD ANY OF THE FOLLOWING

AIDS/HIV	□ YES □ NO	GOITER	□ YES □ NO	PNEUMONIA	□ YES □ NO
ALCOHOLISM	□ YES □ NO	GONORRHEA	□ YES □ NO	POLIO	□ YES □ NO
ALLERGY SHOTS	□ YES □ NO	GOUT	□ YES □ NO	PROSTATE PROBLEM	□ YES □ NO
ANEMIA	□ YES □ NO	HEART DISEASE	□ YES □ NO	PROSTHETICS	□ YES □ NO
ANOREXIA	□ YES □ NO	HEPATITIS	□ YES □ NO	PSYCHIATRIC CARE	□ YES □ NO
APPENDICITIS	□ YES □ NO	HERNIA	□ YES □ NO	RHEUMATOID ARTHRITIS	□ YES □ NO
ARTHRITIS	□ YES □ NO	HERNIATED DIS	□ YES □ NO	RHEUMATOID FEVER	□ YES □ NO
ASTHMA	□ YES □ NO	HERPES	□ YES □ NO	SCARLET FEVER	□ YES □ NO
BLEEDING DISORDERS	□ YES □ NO	HIGH CHOLESTEROL	□ YES □ NO	STROKE	□ YES □ NO
		HIGH BLOOD PRESSURE	□ YES □ NO		
BREAST LUMP	□ YES □ NO	KIDNEY DISEASE	□ YES □ NO	SUICIDE ATTEMPT	□ YES □ NO
BRONCHITIS	□ YES □ NO	LIVER DISEASE	□ YES □ NO	THYROID PROBLEMS	□ YES □ NO
BULIMIA	□ YES □ NO	MEASLES	□ YES □ NO	TONSILITIS	□ YES □ NO
		CANCER	□ YES □ NO		
CATARACTS	□ YES □ NO	MIGRANE	□ YES □ NO	TUBERCULOSIS	□ YES □ NO
MISCARRIAGE	□ YES □ NO	TUMORS GROWTHS	□ YES □ NO	MONONUCLEOSIS	□ YES □ NO
TYPHOID FEVER	□ YES □ NO	CHICKEN POX	□ YES □ NO	MULTIPLE SCLEROSIS	□ YES □ NO
DIABETES	□ YES □ NO	MUMPS	□ YES □ NO	VAGINAL INFECTIONS	□ YES □ NO
EMPHYSEMA	□ YES □ NO	OSTEOPOROSIS	□ YES □ NO	VENERAL DIASEASE	□ YES □ NO
EPILEPSY	□ YES □ NO	PACEMAKER	□ YES □ NO	WHOOPING COUGH	□ YES □ NO
FRACTURES	□ YES □ NO	PARKINSONS DISEASE	□ YES □ NO	ULCERS	□ YES □ NO
GLAUCOMA	□ YES □ NO	PINCHED NERVE	□ YES □ NO		

OTHER _____________

EXERCISE	WORK ACTIVITY	HABITS
□ NONE	□ SITTING	□ SMOKING PACKS/DAY ___________________
□ MODERATE	□ STANDING	□ ALCOHOL DRINKS/WEEK __________________
□ DAILY	□ LIGHT LABOR	□ COFFEE/ CAFFEINE CUPS/DAY ________
□ HEAVY	□ HEAVY LABOR	□ HIGH STRESS LEVEL REASON __

ARE YOU PREGNANT □ YES □ NO DUE DATE

I NURIES/SURGERIES YOU HAVE HAD:	**DESCRIPTION**	**DATE**
FALLS/ ACCIDENTS		
HEAD IN JURIES		
BROKEN BONES		
DISLOCATIONS		
SURGERIES		

MEDICATIONS	ALLERGIES	VITAMINS/HERBS/ MINERALS

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REQUEST FOR RECORDS AND/OR X-RAYS

DATE ____

TO ____

ADDRESS ____

CITY ____

I HEREBY AUTHORIZE THE RELEASE OF MY X-RAYS/ RECORDS OR COPIES THERE OF AND REQUEST THAT THEY BE TRANSFERRED TO:

DEMA REHAB AND INJURY CLINIC, INC

Please fax to:

Orlando Location:

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Tel (407)352-5882 ,Fax: (407)352-5883

Kissimmee Location:

2928 Vineland Rd, Kissimmee, Fl 34746

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NAME OF PATIENT:______________________________

DATE OF RECORDS:______________________________

PATIENT’SIGNATURE:______________________________

PATIENT'S BIRTHDAY: ______________________________

PATIENT'S SOCIAL SECURITY: _______________________

IMPORTANT WARNING: This message is intended for the use of the person or entity to which it is addressed and may contain information that is privileged and confidential, the disclosure of which it is governed by applicable law. If you are not the intended recipient, you are hereby notified that any disclosure, copying or distribution of this information is **strictly prohibited.** If you have received this FAX in error, please notify the sender immediately by telephone and destroy the related message.

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CAUTION ! PLEASE READ BEFORE SIGN IN. IF YOU SIGN BELOW, WE ASSUME YOU UNDERSTAND AND AGREE TO THE TERMS!

Patient's Name ________________________

Release of Information:

I hereby authorize this medical provider to: furnish the insurer's intermediary and the patient's attorney via mail, fax, or email, with any and all information that may be contained in the medical records; to obtain coverage information telephonically form the insurer; to request all EOBs and non-redacted PIP payout sheets forms the insurer; MRIs, form any other medical provider or any insurer. The insurer is directed to keep the patient's medical records private and confidential. The insurer is NOT authorized to provide these medical records to anyone, including but not limited to third party vendors without the patient's and the provider's express written permission.
I certify that I have not been solicited or promised anything in exchanged for receiving medical care or that received an' promises or guarantees from anyone as to the result that may be obtained by any medical treatment.

Signature________________________Date ___________________________(If patient is a minor, Signature of Parent)

Consent form for Chiropractic Adjustment and Care / Terms of Acceptance

I hereby request and consent to the performance of 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 with, or associated with or serving as back-up for the doctor of chiropractic named below, including those working at other Chiropractic Partners offices.

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 with the practice of medicine chiropractic carries some risks to 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. I consent to rely on the doctor's best judgment, exercised during the course of treatment that is in my best interest, based upon the known facts.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its consent, 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 conditions(s) and for any future condition(s) for which I seek treatment.

Signature________________________Date ___________________________(If patient is a minor, Signature of Parent)

AUTHORIZATIO TO OBTAIN PIP BENEFITS

I,__________________________hereby authorize and direct__________________________to send to Dema Rehab & Injury Clinic, Inc.
Insurance name
Patient's Name

an accounting of payouts made under all claims submitted for payment under the above referenced policy relating to the automobile accident occurring on the above referenced date those payouts occur.
Signature________________________Date ___________________________(If patient is a minor, Signature of Parent)

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

By checking the lines below I authorize being contacted for practice reminders by:
□Telephone numbers
□By voice mail
□By text message

Signature________________________Date ___________________________(If patient is a minor, Signature of Parent)

THIS FORM WILL BE PLACED I THE PATIENT'S CHART AND MAINTAINED FOR SIX YEARS

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Assignment of Benefits and Direction to Pay Benefits Owed

I, the undersigned insured or beneficiary of an insurance policy, irrevocably assign to Dema Rehab & Injury Clinic, Inc. on file with the Div. of Corporations, hereafter "Provider") whatever rights I have under any policy of insurance and under Florida law, including, without limitation, any and all claims for
attorney's fees, costs, interest and/or damages pursuant to Florida Statute 624.155. This Assignment of Benefits (AOB) includes an assignment of any potential claim for common law or statutory bad faith. If the Insurer disputes the validity of this AOB, then the insurer is instructed to notify the provider in writing within 10 days of receipt of this document. Failure to do so shall result in the provider relying on this AOB for direct payment and could constitute a waiver by the insurer to contest the validity of this document. I do hereby confirm that this AOB is irrevocable and instruct any insurance company or other collateral source for which I am entitled to benefits to pay for monies owed as a result of medical services rendered by (Provider) to promptly make payment in the name of and directly to (Provider) or its chosen billing service.

Pursuant to this AOB, (Provider) is authorized to file suit on my behalf against any insurance company that reduces or denies benefits for medical services rendered to me and to collect any damages awarded or settlement monies for services rendered, plus interest, costs, reasonable attorney's fees and a contingency fee multiplier. I understand that in any such lawsuit, my name or other identifying information will need to be included in and/or portions of my medical file attached to pleadings and/or formal discovery. I waive any confidentiality of my records and/or information but only to the extent necessary to prosecute a claim for unpaid or owed medical expenses against the insurance company or any other responsible party.

I acknowledge that (Provider) objects to any reductions or partial payments by the Insurer. Any partial or reduced payment, regardless of the accompanying language, issued by the Insurer and deposited by (Provider) shall be done under protest, at the risk of the insurer, and the deposit shall not be deemed a waiver, accord, satisfaction, discharge, settlement or agreement by the provider to accept a reduced amount as payment in full. (Provider) reserves the right to seek the full amount of the bill submitted from the insurance company(ies) or me. Accordingly, the insurer is hereby instructed to set aside (escrow) any and all reduced or denied benefit payments for medical services rendered by this provider and not pay the disputed amount to anyone until the dispute is resolved.

I further instruct my insurance company to cooperate with the above-captioned (Provider) in resolving all medical billing disputes. Cooperation includes, but is not limited to, providing any and all declaration pages, PIP logs, payout ledgers, explanations of benefits, copies of checks, and any and all other documents or information to (Provider) or its attorneys, employees or other representatives acting on behalf of (Provider). If the insurer schedules a defense examination, examination under oath (EUO) or Independent Medical Examination (IME) of the patient, the insurer is hereby instructed to send a copy of said notification to this provider and the provider's attorneys. The provider and/or the provider's
attorneys are authorized to appear at any patient EUO or IME set by the insurer. THIS ASSIGNMENT OF BENEFITS DOES NOT ASSIGN ANY RIGHTS OR OBLIGATIONS UNDER THE POLICY OF INSURANCE, TO SUBMIT TO AN
EUO OR RECORDED STATEMENT. I further direct and authorize you to speak to an attorney, employee or any other representative of (Provider) or anyone acting on their behalf over the phone and provide them with any and all information you may have or documentation not previously listed above that they may request.

I, as the patient, agree to remain personally liable for the amounts billed by (Provider) regardless of the amount paid by the insurance company, unless ordered by a court of law. I fully understand that said health care services were provided to me in consideration for an unconditional promise to pay and for me providing these instructions to my insurance company. I, as the patient, further agree to be liable for reasonable attorney's fees and costs incurred in collecting any delinquent accounts or unpaid balances. By executing this document, I am placing my insurance company(ies) on notice that the claims for medical treatment rendered by (Provider) are related to my accident (or my covered conditions) and should be paid directly to (Provider) pursuant to this assignment of benefits and Florida law. Any delay in paying benefits owed under the insurance policy could adversely affect me.

BY EXECUTING THIS DOCUMENT, I AM PLACING MY INSURANCE COMPANY ON NOTICE THAT THIS IS A DIRECT ASSIGNMENT OF BENEFITS PURSUANT TO FLORIDA LAW. AS THE INSURED OR BENEFICIARY OF SAID INSURANCE POLICY, I AM IRREVOCABLY ASSIGNING WHATEVER RIGHTS I HAVE UNDER MY POLICY OF INSURANCE (LESS THE DUTY TO ATTEND AN EUO) AND UNDER FLORIDA LAW TO THIS HEALTH CARE PROVIDER. A photocopy of this assignment shall be considered as effective and valid as the original.

____
Patient's Name/DOB   Signature of Policy holder or Claimant

____
Name of Policy holder or Claimant Acceptance of (Provider)   Dated:__________________

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