CHAMBERS MEDICAL GROUP
711 North Lake Paker Avenue * Lakeland, FL 33801 * (863) 683-0046 * (863) 638-0819 fax

PERSONAL INFORMATION: PLEASE PRINT

MISS/MRS/MS/MR: _____ AGE: ____
FIRST MIDDLE MAIDEN LAST

DATE OF BIRTH: ____/____/____ MALE/FEMALE SINGLE / MARRIED / D
MONTH DAY YEAR PLEASE CIRCLE ONE

MAILING ADDRESS: _____
NUMBER & STREET CITY STATE ZIP

HOME PHONE: ( ) _____ SOCIAL SECURITY# _____

CELL/ALTERNATE: ( )

EMPLOYER INFORMATION: PLEASE PRINT

COMPANY NAME: _____ PHONE: _____

OCCUPATION: _____

_____
ADDRESS NUMBER & STREET CITY STATE ZIP

SPOUSE INFORMATION: PLEASE PRINT

NAME: _____ OCCUPATION: _____
FIRST MIDDLE MAIDEN LAST

IN CASE OF EMERGENCY CONTACT: _____ RELATIONSHIP: _____

PHONE: _____ ALTERNATE: _____

*** IN ORDER THAT WE DO NOT HAVE TO REPEAT ANY TESTS THAT HAVE ALREADY BEEN PERFORMED, PLEASE OBTAIN ALL MEDICAL REPORTS, X-RAYS, PHYSICAL THERAPY REPORTS AND REHABILITATION REPORTS. THIS INFORMATION WILL ALSO PROVIDE NECESSARY DATES WHICH ARE NEEDED FOR A COMPLETE EVALUATION OF YOUR INJURIES AND ILLNESS.**

RELEASE OF MEDICAL RECORDS: PLEASE PRINT

*** I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM AND REQUEST PAYMENT OF ALL MEDICAL BENEFITS TO BE MADE DIRECTLY TO THE PHYSICIAN OR SUPPLIER LISTED ON THIS FORM.**

PATIENT SIGNATURE:_____ ***DATE:***_____

*** PLEASE CIRCLE ONE OR BOTH - PHYSICIAN / ATTORNEY**

PHYSICIAN NAME:_____ PHONE:_____

ATTORNEY NAME:_____ PHONE:_____

*** I FURTHER AUTHORIZE INFORMATION TO BE RELEASED TO MY PHYSICIAN / ATTORNEY AS INDICATED ABOVE.**

PATIENT SIGNATURE:_____ ***DATE:***_____

CLINIC: LAKELAND

ACCIDENT INFORMATION:

PATIENT NAME: _____ DATE OF ACCIDENT: _____

TYPE OF ACCIDENT: CIRCLE ONE AUTO / BUS / RENTAL CAR / WORKERS COMP / FALL / OTHER: _____

DRIVER OR PASSENGER CIRCLE ONE NAME OF CAR OWNER: _____

RELATIONSHIP: _____

AUTO INSURANCE INFORMATION (PLEASE PRINT)

NAME OF INSURED: _____ RELATIONSHIP TO INSURED: _____

NAME OF INSURANCE COMPANY: _____

ADDRESS: _____ PHONE NUMBER: _____

HAS ACCIDENT BEEN REPORTED: Y OR N CLAIM#: _____

POLICY#: _____

FOR OFFICE USE ONLY

ADJ: _____ DEDUCTIBLE MET: Y OR N

COVERAGE INFO: DEDUCTIBLE: COVERAGE: 80% 100% MEDPAY: Y OR N

HEALTH INSURANCE INFORMATION (PLEASE PRINT)

NAME OF INSURED: _____ PATIENT I. D. # _____

DATE OF BIRTH INSURED: _____ GROUP # _____

RELATIONSHIP TO INSURED: _____ EFFECTIVE DATE: _____

EMPLOYER NAME: _____

NAME OF HEALTH INSURANCE COMPANY: _____

ADDRESS: _____ PHONE: _____

FOR OFFICE USE ONLY:

DED: MET: Y OR N COVERAGE: OUT OF NETWORK BENEFITS: Y OR N

WORKERS COMPENSATION INFORMATION (PLEASE PRINT)

EMPLOYER'S NAME: _____ PHONE: _____

WORKER'S COMP. CARRIER: _____ FAX #: _____

ADDRESS: _____ ADJUSTER: _____

FOR OFFICE USE ONLY DOCTOR: _____

INFORMATION TAKEN BY: _____

DIAGNOSIS CODES: _____ _____ _____

_____ _____ _____

CHAMBERS MEDICAL GROUP
711 NORTH LAKE PARKER AVE.
LAKELAND, FL 33801
(863) 683-0046 FAX (863) 683-0819

AUTHORIZATION FOR RELEASE OF RECORDS

I hereby authorize the use of disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider the released information may no longer be protected by federal privacy regulations.

Patient Name: _____ SS# Number: _____

I hereby authorize the following Doctor, Office or Institution,

_____

_____

to release a copy of my protected health information to:

CHAMBERS MEDICAL GROUP
711 NORTH LAKE PARKER AVE.
LAKELAND, FL 33801
(863) 683-0046 FAX (863) 683-0819

Specific description of information requested:

___All Medical Records ____X-ray Reports ____MRI Reports ___CT Reports ___Narrative Reports

___X-ray Films ____MRI Films ____Nerve Conduction / EMG Studies

___Emergency Room Records ____Hospital Inpatient Records ____Physical Therapy Records

Other:_____

Dates: From _____ To: _____

1. The provider must complete the following statement:

a. Will the healthcare provider requesting the authorization receive financial or in-kind compensation in exchange for using or disclosing the health information described above? Yes ____ No XXX

2. The patient must read and initial the following statement:

a. I understand that I may request a copy of this form after I sign it. Pt. initials _____

Section C: Must be completed for all authorizations

The patient or the patient's representative must read and initial the following statements:
1. I understand that this authorization will expire on __ __/__ __/__ __ __ __ (DD/MM/YYYY) Initials: _____
2. I understand that I may revoke this authorization at any time by notifying the practice in writing, but if I do it won't have any affect on any actions that took place before they received the revocation. Initials: _____

_____ _____

Signature of patient or patient's representative Date
(*Form MUST be completed before signing)*

Printed name of patient's representative: _____

Relationship to the patient: _____

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION

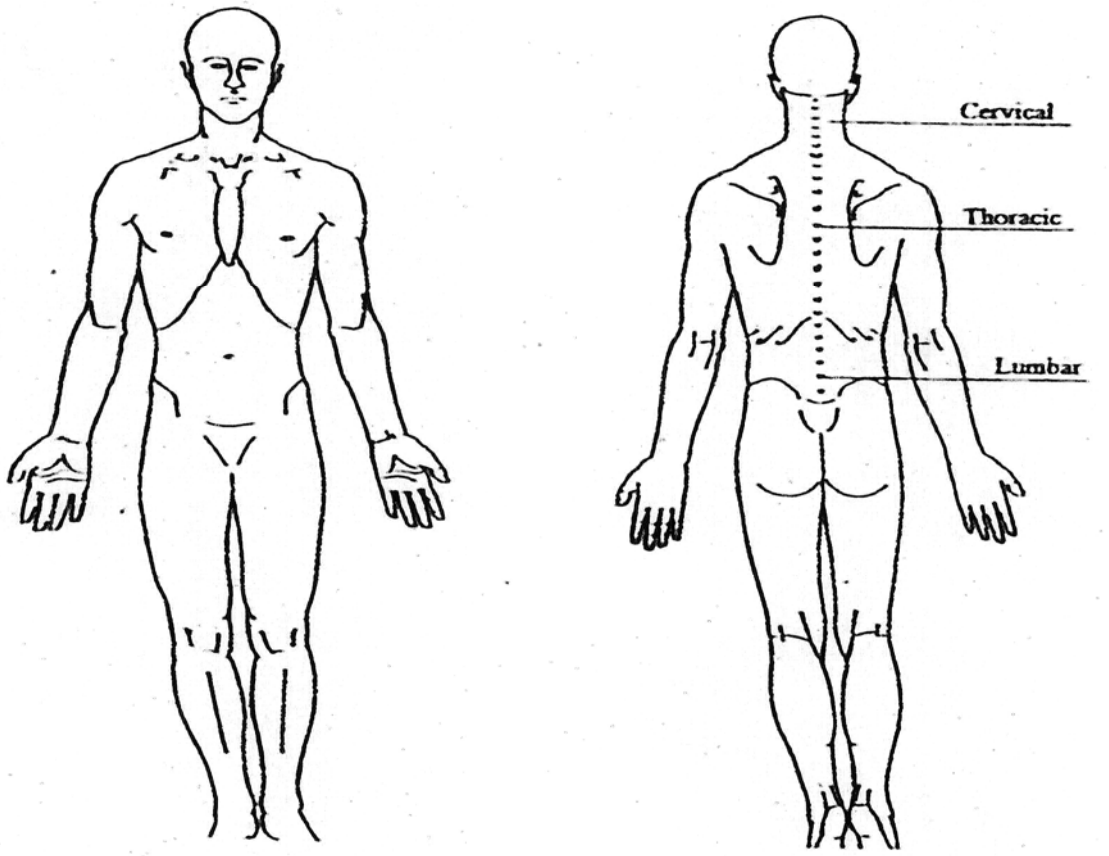
CHAMBERS
Medical Group

Patient Name:_____ **Date of Accident:**_____

Patient Injury Identification

Draw or shade in the location of your body injuries as a result of you most recent accident. Describe, by connecting a line to the area of the body diagram. Note pain, stiffness, weakness, numbness, cuts, black and blue marks, swelling and scars. Carefully scan your entire body pushing on areas to note tenderness. Move arms, legs, back including pain during activities such as lifting, bending and working. This is very important so the physician doesn't overlook any injuries.

RIGHT **LEFT** **LEFT** **RIGHT**



CHECK THE APPROPRIATE BOX FOR ANY SYMPTOMS THAT APPEARED AS A RESULT OF THE ACCIDENT/INJURY:

- ❑ **Headache**
- ❑ **Neck Pain**
- ❑ **Mid Back Pain**
- ❑ **Low Back Pain**
- ❑ **Shoulder Pain L/R**
- ❑ **Elbow Pain L/R**
- ❑ **Wrist/Hand Pain L/R**
- ❑ **Hip Pain L/R**
- ❑ **Knee Pain L/R**
- ❑ **Ankle/Foot Pain L/R**
- ❑ **Numbness of _____**
- ❑ **Tingling of _____**
- ❑ **Sleep Difficulties**
- ❑ **Jaw Pain L/R**
- ❑ **Other_____**

CHAMBERS MEDICAL GROUP
INFORMED CONSENT TO TREATMENT

The purpose of this form is to make you, the patient, aware of the possible risks of the different treatment modalities routinely provided at Chambers Medical Group. If you are referred to one or our specialists (orthopedic surgery, interventional pain management, etc.) they will have an additional form to advise you of the risks of their procedures.

MEDICATION: possible risks include allergic reaction, dependence, liver and kidney function problems, affects on heart, drowsiness, etc. Caution should be used as medication can mask progress, and the danger of side effects and damage to the health of the person taking the medication is well documented. Risk probability is moderate.

THERAPY: possible risks include burns induced by heat (causing temporary pain and possible blistering), temporary pain due to massage or adjunctive therapies. Risk probability is extremely rare.

TRIGGER POINT INJECTIONS: possible pneumothorax, localized reaction to medication, allergic reaction. Risk probability is extremely rare.

CHIROPRACTIC CARE: possible fracture of bone, sprain of ligament, strain of muscle, cerebrovascular injury (stroke) could occur upon severe injury to the arteries of the neck with an extension-rotation-thrust atlas adjustment - that type of adjustment is NOT performed in our offices. Risk probability is extremely rare.

OTHER PROBLEMS: there may be other problems or complications arising from treatment such as massage, traction, etc., other than noted above. These other problems occur so rarely it is not possible to anticipate/explain them in advance. Risk probability is extremely rare.

ALTERNATIVE TREATMENTS

HOSPITALIZATION: proven expensive and exposes the patient to communicable disease and possible doctor/staff mishap. Risk probability is moderate.

SURGERY: risks include reaction to anesthesia, doctor error, and the risks imposed by hospitalization during convalescent period. Risk probability is substantial.

NON TREATMENT: can result in adhesions, pain, and reduction in joint mobility, which can lead to degenerative joint disease. Risk probability is moderate.

At **CHAMBERS MEDICAL GROUP** we use a system of health care delivery. As with any health care system, we cannot promise a cure for any symptom, disease, or condition as a result of treatment in this clinic. We will always give you our best care, and if results are not acceptable we will refer you to another provider who we feel will better assist your situation.

If you have any questions about the above information, please ask your doctor. When you have a full understanding of this consent form, please sign below and date below.

I hereby authorize and direct **CHAMBERS MEDICAL GROUP** to provide such service as they deem reasonable and necessary.

I HEREBY STATE THAT I HAVE READ THIS CONSENT FORM.

_____ _____

Patient Witness

_____

Date

Chambers Medical Group

Patient Questionnaire

Patient Name _____ Age _____ Date_____

1. Accident/Injury Type: ☐Auto, ☐Slip/Fall, ☐On Job Injury, ☐Other (Please specify) _____

2. Date of Accident/Injury:_____ Location:_____

3. Were you wearing a seatbelt ☐Y or ☐N were you the ☐Driver ☐Passenger ☐Front seat ☐Back seat

4. Were you struck in the: ☐Front, ☐Rear, ☐Driver's side, ☐ Passenger's side?

5. Were you knocked unconscious? ☐Yes, ☐No. If yes for how long? _____

6. Were you examined by paramedics, EMT or any other first responder after the accident? ☐Yes ☐ No

7. Did you go to the hospital? ☐Yes ☐No If yes, name of Hospital _____

   How did you get there? ☐Ambulance ☐Self ☐Driven by_____

8. Were X-Rays taken? ☐Yes, ☐No. Were you given medication? ☐Yes, ☐ No

9. Were you told the diagnosis? ☐Yes, ☐No….If yes please describe_____

10. Have you been treated by another Dr. since the accident? ☐Yes, ☐No…..If yes please list the Dr's name and address:_____

    What treatment did you receive? _____

11. Have you ever had similar symptoms prior to the accident/injury? ☐Yes ☐No. Please describe____

    _____

12. Have you ever been involved in an accident before? ☐Yes ☐No….If yes please describe, including dates and injuries. _____

13. Have you ever had any surgeries? ☐Yes, ☐No….If yes please describe_____

    _____

    If yes, do you have any surgical implants? (such as metal rods, pacemaker) _____

14. Do you have any health problems we need to know about (including any allergies to medications)?

    ☐Yes, ☐No. Please describe_____

15. Allergies? _____

16. Current medications? _____

17. Pregnant? ☐ Yes ☐ No (if yes, expected due date.) _____

18. Have you lost time from work as a result of this accident? ☐Yes, ☐No…..If yes please complete these questions: a) Dates missed__/__/__ through __/__/__. b) Type of work_____

19. If this was an auto accident how many people were in the car?_____

APPLICATION FOR FLORIDA "NO FAULT" BENEFITS

NAME OF INSURANCE COMPANY

DATE	OUR POLICY HOLDER	DATE OF ACCIDENT	FILE NUMBER

TO ENABLE US TO DETERMINE IF YOU ARE ENTITLED TO BENEFITS UNDER THE FLORIDA PERSONAL INJURY PROTECTION LAW, PLEASE COMPLETE THIS FORM AND RETURN IT PROMPTLY.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD OR DECEIVE ANY INSURANCE COMPANY MAKES A STATEMENT OF CLAIM CONTAINING ANY FALSE INCOMPLETE OR MISLEADING INFORMATION, IS GUILTY OF A FELONY OF THE THIRD DEGREE.

YOUR NAME	PHONE NO.	HOME	BUSINESS

YOUR ADDRESS (NO, STREET, CITY OR TOWN, STATE AND ZIP CODE)	DATE OF BIRTH	SOCIAL SECURITY NO.

PERMANENT ADDRESS, IF DIFFERENT	HOW LONG HAVE YOU LIVED IN FLORIDA?

DATE AND TIME OF ACCIDENT	PLACE OF ACCIDENT (STREET, CITY OR TOWN AND STATE)

BRIEF DESCRIPTION OF ACCIDENT AND VEHICLES INVOLVED:

DESCRIBE MOTOR VEHICLE YOU OWN -	DESCRIBE MOTOR VEHICLE OWNED BY ANY MEMBER OF YOUR FAMILY-

AS A RESULT OF THIS ACCIDENT, WERE YOU INJURED? IF YOUR ANSWER IS YES, COMPLETE THE REST OF THIS FORM. IF NO, SIGN HERE AND RETURN THIS FORM TO US.

SIGNATURE: **DATE:**

DESCRIBE YOUR INJURY

WERE YOU TREATED BY A DOCTOR?		DOCTOR'S NAME AND ADDRESS
IF YOU WERE TREATED IN A HOSPITAL, WERE YOU AN IN PATIENT ____ OUT PATIENT _____		HOSPITAL'S NAME AND ADDRESS

AMOUNT OF MEDICAL BILLS TO DATE	WILL YOU HAVE MORE MEDICAL EXPENSE?	AT THE TIME OF YOUR ACCIDENT, WERE YOU IN THE COURSE OF YOUR EMPLOYMENT?

DID YOU LOSE WAGES OR SALARY AS A RESULT OF YOUR INJURY?	IF YES, AMOUNT OF LOSS TO DATE	WHAT IS YOUR AVERAGE WEEKLY WAGE OR SALARY?

IF YOU LOST WAGES:	DATE DISABILITY FROM WORK BEGAN	DATE YOU RETURNED TO WORK

HAVE YOU RECEIVED, OR ARE YOU ELIGIBLE FOR, PAYMENTS UNDER ANY WORKMEN'S COMPENSATION OR EMPLOYMENT LAW?	IF YES, AMOUNT PER WEEK PER MONTH

LIST NAMES AND ADDRESSES OF YOUR PRESENT EMPLOYER(S) AND GIVE YOUR OCCUPATION AND DATES OF EMPLOYMENT FOR EACH

EMPLOYER AND ADDRESS	YOUR OCCUPATION	FROM	TO
EMPLOYER AND ADDRESS	YOUR OCCUPATION	FROM	TO
EMPLOYER AND ADDRESS	YOUR OCCUPATION	FROM	TO

AS A RESULT OF YOUR INJURY HAVE YOU HAD ANY OTHER EXPENSES?	IF YES, EXPLAIN ON REVERSE SIDE
SIGNATURE: DATE:	

IMPORTANT: 1. TO BE ELIGIBLE FOR BENEFITS COMPLETE AND SIGN THIS APPLICATION
2. SIGN AND ATTACH AUTHORIZATION(S)
3. RETURN PROMPTLY WITH ANY MEDICAL BILLS YOU HAVE RECEIVED TO DATE

DO NOT DETACH

AUTHORIZATION FOR MEDICAL INFORMATION

THIS AUTHORIZATION OR PHOTOCOPY HEREOF, WILL AUTHORIZE YOU TO FURNISH ALL INFORMATION YOU MAY HAVE REGARDING MY CONDITION WHILE UNDER YOUR OBSERVATION OR TREATMENT, INCLUDING THE HISTORY OBTAINED, X-RAY AND PHYSICAL FINDINGS DIAGNOSIS AND PROGNOSIS. YOU ARE AUTHORIZED TO PROVIDE THIS INFORMATION IN ACCORDANCE WITH THE FLORIDA “NO FAULT” AUTO INSURANCE LAW (CHAPTER 71-252 F.S.)

_____

SIGNATURE DATE

DO NOT DETACH

AUTHORIZATION FOR WAGE AND SALARY INFORMATION

THIS AUTHORIZATION OR PHOTOCOPY HEREOF, WILL AUTHORIZE YOU TO FURNISH ALL INFORMATION YOU MAY HAVE REGARDING MY WAGES OR SALARY WHILE EMPLOYED BY YOU. YOU ARE AUTHORIZED TO PROVIDE THIS INFORMATION IN ACCORDANCE WITH THE FLORIDA “NO FAULT” AUTO INSURANCE LAW (CHAPTER 71-252 F.S.)

_____

SIGNATURE DATE

SOCIAL SECURITY NO.