CHAMBERS MEDICAL GROUP
BRECKENRIDGE CLINIC

2932 BRECKENRIDGE LANE, SUITE 1
LOUISVILLE, KY 40220
PH (502) 479-1616
FAX (502) 479-1619

PATIENT INTAKE FORM - PLEASE PRINT

PERSONAL INFORMATION

NAME _____ EMAIL _____
FIRST MIDDLE - MAIDEN LAST

DATE OF BIRTH _____ GENDER _____ MARITAL STATUS _____
MONTH / DAY / YEAR SINGLE / MARRIED / DIVORCED

MAILING ADDRESS _____
NUMBER & STREET CITY STATE ZIP

PHONE _____ ALT PHONE _____ SOCIAL SECURITY NO. _____

EMPLOYER INFORMATION

COMPANY NAME _____ OCCUPATION _____

ADDRESS _____
NUMBER & STREET CITY STATE ZIP

PHONE _____

SPOUSE INFORMATION - EMERGENCY CONTACT

NAME _____
FIRST MIDDLE MAIDEN LAST

RELATIONSHIP _____ OCCUPATION _____

PHONE _____ ALT PHONE _____

RELEASE OF MEDICAL RECORDS

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.

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 _____
MONTH / DAY / YEAR

PHYSICIAN NAME _____ PHONE _____

ATTORNEY NAME _____ PHONE _____

I further authorize information to be released to my Physician / Attorney as indicated above.*
*Please circle one or both – Physician / Attorney.

PATIENT SIGNATURE _____ DATE _____
MONTH / DAY / YEAR

ACCIDENT INFORMATION

PATIENT NAME _____
FIRST MIDDLE MAIDEN LAST

DATE OF ACCIDENT _____ ☐DRIVER OR ☐PASSENGER
MONTH / DAY / YEAR

NAME OF CAR OWNER ☐ PATIENT OR ☐OTHER _____ RELATIONSHIP _____
FIRST LAST

TYPE OF ACCIDENT ☐ AUTO ☐ BUS ☐ RENTAL CAR ☐ WORKERS COMP ☐ FALL ☐ OTHER _____

AUTO INSURANCE INFORMATION

NAME OF INSURED _____
FIRST MIDDLE MAIDEN LAST

EFFECTIVE DATE _____ RELATIONSHIP TO INSURED _____
MONTH / DAY / YEAR

NAME OF AUTO INSURANCE COMPANY _____

ADDRESS _____ PHONE _____
NUMBER & STREET CITY STATE ZIP

HAS ACCIDENT BEEN REPORTED ☐ YES ☐ NO CLAIM NO. _____ POLICY NO. _____

FOR OFFICE USE ONLY

ADJ _____ COVERAGE INFO _____

DEDUCTIBLE _____ DEDUCTIBLE MET - ☐ YES ☐ NO COVERAGE - ☐ 80 ☐ 100 MEDPAY - ☐ YES ☐ NO

HEALTH INSURANCE INFORMATION

NAME OF INSURED _____
FIRST MIDDLE MAIDEN LAST

PATIENT I.D. NO. _____ D.O.B. OF INSURED _____ GROUP NO. _____
MONTH / DAY / YEAR

EFFECTIVE DATE _____ RELATIONSHIP TO INSURED _____
MONTH / DAY / YEAR

EMPLOYER NAME _____

NAME OF HEALTH INSURANCE COMPANY _____

ADDRESS _____ PHONE _____
NUMBER & STREET CITY STATE ZIP

FOR OFFICE USE ONLY

DED _____ MET - ☐ YES ☐ NO COVERAGE _____ OUT OF NETWORK BENEFITS - ☐ YES ☐ NO

WORKERS COMPENSATION INFORMATION

EMPLOYER'S NAME _____ PHONE _____

WORKERS COMP. CARRIER _____ FAX _____

ADDRESS _____ ADJUSTER _____
NUMBER & STREET CITY STATE ZIP

FOR OFFICE USE ONLY

DOCTOR _____ INFORMATION TAKEN BY _____

DIAGNOSIS CODES _____

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AUTHORIZATION FOR RELEASE OF RECORDS

RELEASE

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 _____ SOCIAL SECURITY NO. _____
FIRST LAST

I HEREBY AUTHORIZE _____
DOCTOR, OFFICE, OR INSTITUTION

TO RELEASE A COPY OF MY PROTECTED HEALTH INFORMATION TO CHAMBERS MEDICAL GROUP
2932 BRECKENRIDGE LANE, SUITE 1 LOUISVILLE, KY 40220

SPECIFIC DESCRIPTION OF INFORMATION

☐ ALL MEDICAL RECORDS
☐ NARRITIVE REPORTS
☐ EMERGENCEY ROOM RECORDS
☐ X-RAY REPORTS
☐ X-RAY FILMS
☐ HOSPITAL INPATIENT RECORDS
☐ MRI REPORTS
☐ MRI FILMS
☐ CT REPORTS
☐ PHYSICAL THERAPY RECORDS
☐ NERVE CONDUCTION / EMG STUDIES
☐ OTHER:

FROM DATES _____ TO _____
MONTH / DAY / YEAR MONTH / DAY / YEAR

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

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.

PATIENT INITIALS _____

PATIENT REPRESENTATIVE

SECTION C: The patient or the patient's representative must read and initial the following statements:

1. I understand that this authorization will expire on _____ PATIENT INITIALS _____
   MONTH / DAY / YEAR
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. PATIENT INITIALS _____

SIGNATURE OF PATIENT/ PATIENT REPRESENTATIVE _____ DATE _____
MONTH / DAY / YEAR

NAME OF PATIENT REPRESENTATIVE _____ RELATIONSHIP _____

Form must be completed before signing. You may refuse to sign this authorization

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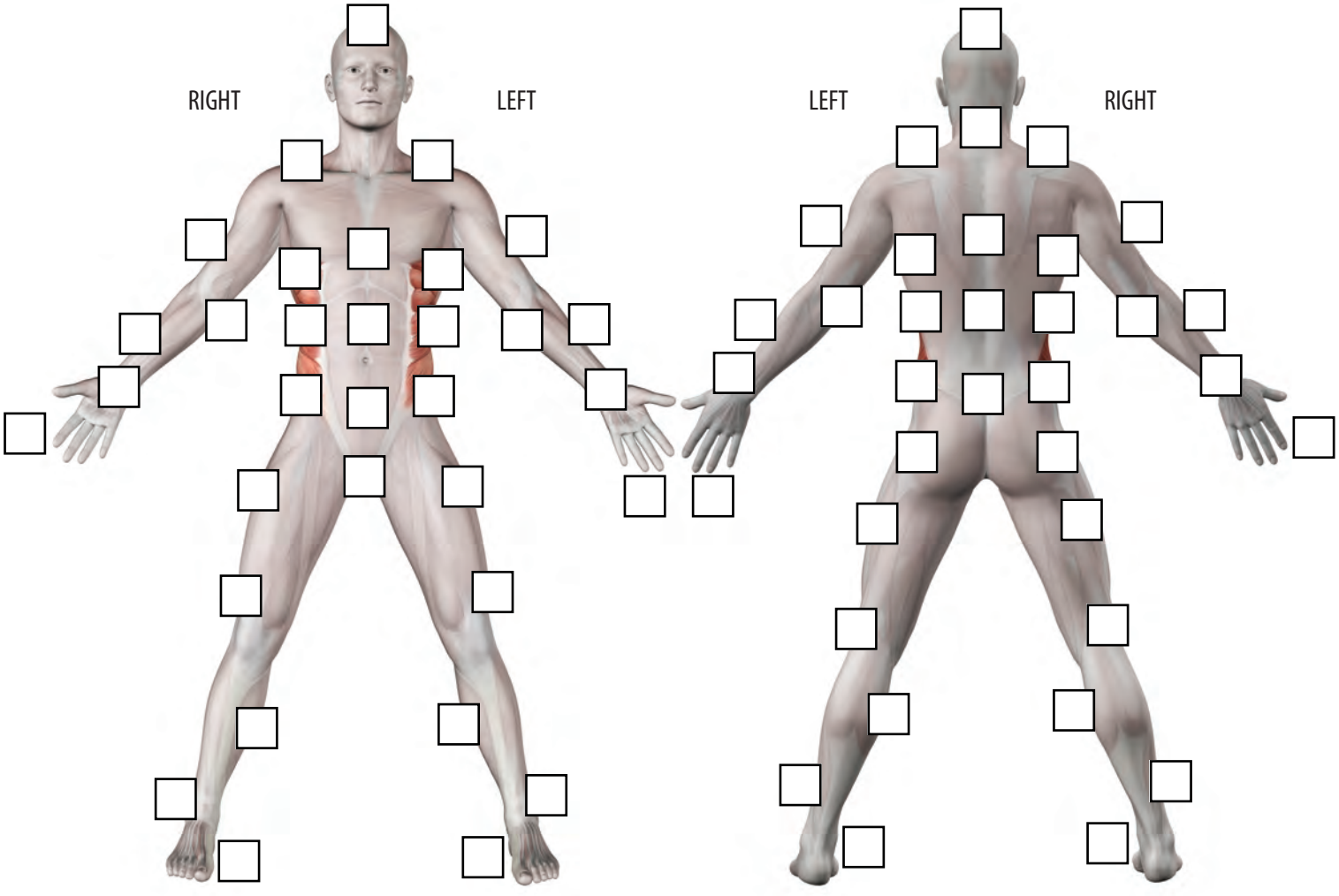
PATIENT INJURY IDENTIFICATION

RELEASE

Draw or shade in the location of your body injuries that are as a result of your 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, and back and include notes about pain during activities such as lifting, bending and working. This is very important so the physician doesn't overlook any injuries.

PATIENT NAME _____ DATE OF ACCIDENT _____
FIRST LAST MONTH / DAY / YEAR



SELECT ALL SYMPTOMS THAT APPEARED AS A RESULT OF YOUR ACCIDENT/INJURY

☐ HEADACHE	☐ SHOULDER PAIN - LEFT	☐ WRIST/HAND PAIN – LEFT	☐ KNEE PAIN - LEFT	☐ JAW PAIN - LEFT
☐ NECK PAIN	☐ SHOULDER PAIN - RIGHT	☐ WRIST/HAND PAIN – RIGHT	☐ KNEE PAIN - RIGHT	☐ JAW PAIN - RIGHT
☐ LOW BACK PAIN	☐ ELBOW PAIN - LEFT	☐ HIP PAIN - LEFT	☐ ANKLE PAIN - LEFT	☐ SLEEP DIFFICULTIES
☐ MID BACK PAIN	☐ ELBOW PAIN - RIGHT	☐ HIP PAIN - RIGHT	☐ ANKLE PAIN - RIGHT	☐ OTHER: _____
☐ NUMBNESS OF _____		☐ TINGLING OF _____		_____

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INFORMED CONSENT TO TREATMENT

RELEASE

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 SIGNATURE _____ DATE _____
MONTH / DAY / YEAR

WITNESS SIGNATURE _____

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PATIENT QUESTIONNAIRE

PATIENT DETAILS

Patient Name _____ Age _____ Date _____ (MONTH / DAY / YEAR)

Accident/Injury Type ☐ Auto ☐ Slip/Fall ☐ On the Job ☐ Other: _____

Date of Accident/Injury _____ (MONTH / DAY / YEAR) Location _____

Were you wearing a seatbelt? ☐ Yes ☐ No You were the ☐ Driver ☐ Passenger - ☐ Front seat ☐ Back seat

In your own words, please describe the accident/injury _____

_____

Were you struck in the ☐ Front ☐ Rear ☐ Driver's side ☐ Passenger's side

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

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

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

Drivin to the Hospital by ☐ Ambulance ☐ Self ☐ Other _____

Were X-Rays taken? ☐ Yes ☐ No

Were you given medication? ☐ Yes ☐ No

Were you told the diagnosis? ☐ Yes ☐ No If yes please describe _____

_____

Have you been treated since the accident? ☐ Yes ☐ No If yes please include doctor's name, address, and treatment below

Name _____ Address _____ (NUMBER & STREET / CITY / STATE / ZIP)

Describe treatment _____

Have you ever had similar symptoms prior to the accident/injury? ☐ Yes ☐ No If yes please describe _____

_____

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

_____

Have you ever had any surgeries? ☐ Yes ☐ No If yes please describe _____

Do you have any surgical implants ☐ Yes ☐ No If yes please describe _____

Do you have any health problems we need to know about (including any allergies to medications)? ☐ Yes ☐ No If yes please describe

_____

List any allergies _____

List any current medications _____

Are you Pregnant? ☐ Yes ☐ No If yes, expected due date _____

Have you lost time from work as a result of this accident? ☐ Yes ☐ No If yes please complete details below

Dates missed _____ (MONTH / DAY / YEAR) through _____ (MONTH / DAY / YEAR) Type of work _____

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

KENTUCKY NO FAULT

IMPORTANT:
A. TO ENABLE US TO DETERMINE IF YOU ARE ENTITLED TO BENEFITS UNDER THE POLICYHOLDER'S INSURANCE CONTRACT, YOU MUST COMPLETE AND SIGN THIS FORM
B. YOU MUST ALSO SIGN THE ATTACHED AUTHORIZATION (S).
C. RETURN PROMPTLY WITH ANY MEDICAL BILLS YOU HAVE RECEIVED TO DATE.

DATE	OUR POLICYHOLDER	DATE OF ACCIDENT	FILE NUMBER

TO: _____
CLAIM DEPARTMENT

_____
NAME OF COMPANY

1. YOUR NAME | HOME PHONE NUMBER | BUSINESS PHONE NUMBER

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

3. DATE AND TIME OF ACCIDENT | PLACE OF ACCIDENT (STREET, CITY OR TOWN AND STATE)
A.M. ☐
P.M. ☐

4. BRIEF DESCRIPTION OF ACCIDENT

5. DO YOU OR ANY MEMBER OF YOUR HOUSEHOLD OWN A MOTOR VEHICLE? YES ☐ NO ☐

IF "YES," NAME OF INSURANCE COMPANY _____ POLICY NUMBER _____

WERE YOU THE DRIVER OF THE MOTOR VEHICLE?	YES ☐ NO ☐
WERE YOU A PASSENGER IN THE MOTOR VEHICLE?	YES ☐ NO ☐
WERE YOU A PEDESTRIAN?	YES ☐ NO ☐
WERE YOU A MEMBER OF THE MOTOR VEHICLE OWNER'S HOUSEHOLD?	YES ☐ NO ☐
HAVE YOU REJECTED THE LIMITATIONS ON YOUR RIGHT TO SUE AS PROVIDED BY KENTUCKY NO-FAULT ACT (KRS 304.39)?	YES ☐ NO ☐

6. AS A RESULT OF THIS ACCIDENT, WERE YOU INJURED?
YES ☐ (IF YOUR ANSWER IS "YES", COMPLETE THE REST OF THIS FORM.)
NO ☐ (IF "NO," SIGN HERE AND REURN THIS FORM TO US.)

_____ _____
Signature Date

7. DESCRIBE YOUR INJURY

8. WERE YOU TREATED BY A DOCTOR? YES ☐ NO ☐ DOCTOR'S NAME AND ADDRESS

9. IF YOU WERE TREATED IN A HOSPITAL, WERE YOU AN IN-PATIENT ☐ OUT-PATIENT ☐ HOSPITAL'S NAME AND ADDRESS

10. AMOUNT OF MEDICAL BILLS TO DATE $_____
WILL YOU HAVE MORE MEDICAL EXPENSE? YES ☐ NO ☐
AT THE TIME OF YOUR ACCIDENT, WERE YOU IN THE COURSE OF YOUR EMPLOYMENT? YES ☐ NO ☐

11. DID YOU LOSE WAGES OR SALARY AS A RESULT OF YOUR INJURY? YES ☐ NO ☐

IF "YES," AMOUNT LOST TO DATE $_____

WHAT IS YOUR AVERAGE WEEKLY WAGE OR SALARY? $_____

12. IF YOU LOST WAGES:
BEGINNING DATE OF DISABILITY FROM WORK: _____ DATE RETURNED TO WORK _____

1-2003

13. HAVE YOU RECEIVED OR ARE YOU ELIGIBLE FOR BENEFITS UNDER
1. ANY WORKMEN'S COMPENSATION LAW? YES ☐ NO ☐

IF "YES," AMOUNT: $_____ PER WEEK ☐ PER MONTH ☐

2. SOCIAL SECURITY BENEFITS? YES ☐ NO ☐

14. LIST NAMES & ADDRESSES OF YOUR EMPLOYER & OTHER EMPLOYERS FOR 1 YEAR PRIOR TO ACCIDENT DATE. GIVE OCCUPATION & EMPLOYMENT DATES.

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

I hereby authorize release of medical information, including but not limited to, medical bills and reports, to such persons as the company may deem necessary.

15. AS A RESULT OF YOUR INJURY, HAVE YOU HAD ANY OTHER EXPENSES? YES ☐ NO ☐
IF "YES", explain:

WARNING

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE CONTAINING ANY MATERIALLY FALSE INFORMATION OR CONCEALS, FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME.

_____ _____
Signature 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 PHYSICAL FINDINGS, DIAGNOSIS AND PROGNOSIS. YOU ARE AUTHORIZED TO PROVIDE THIS INFORMATION IN ACCORDANCE WITH THE PERSONAL INJURY PROTECTION BENEFITS (KENTUCKY NO-FAULT) LAW.

_____ _____
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 PERSONAL INJURY PROTECTION BENEFITS (KENTUCKY NO-FAULT) LAW.

_____ _____
Signature Date

MAIL COMPLETED FORM TO:

KENTUCKY ASSIGNED CLAIMS PLAN
Suite 100, 10605 Shelbyville Road
Louisville, Kentucky 40223

1-2003