North Pinellas Spine & Joint

Dr. Joshua Bly

36949 U.S. Hwy. 19 North • Palm Harbor, Florida 34684 TEL: (727) 934-7602 FAX: (727) 934-7704

Last Name First Name MI

Patient record#: _____

Date of Birth: ____/____/_____

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing below, I am acknowledging that:

- I am either the patient or the patient's personal representative;
- I have received a copy of the "Notice of Privacy Practices" for _____ County/District Health Department; and
- I understand that I may contact the person named in the Notice if I have questions about the content of the Notice.

_____ _____

Signature of patient or parent/legal guardian/legally responsible person Date

_____

Description of relationship to patient

TO BE COMPLETED BY STAFF

Complete all applicable parts—Please refer to instructions

Part 1. Complete if signature requested but not obtained:
Staff member sought but was unable to obtain an acknowledgment from the patient or the patient's personal representative for the following reason:

☐ Patient/personal representative refused to sign form

☐ Other _____

_____

Part 2. Complete if patient/personal representative unavailable to sign form on first date of service delivery:
☐ Form mailed/sent to patient/personal representative on _____.

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AUTO ACCIDENT QUESTIONNAIRE

GENERAL INFORMATION

Patient Name: _____ Date: _____

Sex: ☐ Male ☐ Female Date of Birth: _____ S/S #: _____

Address: _____ City: _____ State: _____

Zip: _____ Home Phone: _____ Cell Phone: _____

Employer's Name: _____ Work Phone: _____

INSURANCE INFORMATION

Your Ins. Co.: _____ Claim #: _____

Name on Policy (If other than self): _____ Date of Birth: _____

Personal Health Plan: _____ ID#: _____ Group: _____

Policy Holder's Name: _____ Date of Birth: _____ Relation to Patient: _____

ATTORNEY INFORMATION

Name: _____ Phone (_____) _____

Address: _____ City: _____ State: _____ Zip: _____

Date of Accident: _____ Were you: ☐ Driver ☐ Passenger ☐ Front seat ☐ Back Seat

Number of People in your vehicle? _____ Were you wearing seat belts? ☐ Yes ☐ No

What direction were you headed? ☐ North ☐ East ☐ South ☐ West

On (name of street) _____

What was Year _____ Make _____ Model _____ of your vehicle?

What direction was other vehicle headed? ☐ North ☐ East ☐ South ☐ West

On(name of street) _____

What was Year _____ Make _____ Model _____ of other vehicle?

Were you struck from: ☐ Behind ☐ Front ☐ Left side ☐ Right side

Road conditions: ☐ Dry ☐ Damp ☐ Wet ☐ Snow ☐ Ice ☐ other

Time of day _____ ☐ am ☐ pm ☐ Daylight ☐ Dawn ☐ Dusk ☐ Night

Did your vehicle have a headrest? ☐ Yes ☐ No

Did the headrest come up to: ☐ Top of Back ☐ Middle of head ☐ Top of Head

Was seat back position altered after the accident? ☐ Yes ☐ No

Did air bag deploy? ☐ Yes ☐ No

What was your head position at the time of impact? ☐ Straight Ahead ☐ Right ☐ Left ☐ Other

What were your hand positions? ☐ Right on Wheel ☐ Left on Wheel ☐ Other _____

AUTO ACCIDENT QUESTIONNAIRE

If passenger, describe body position at time of impact:

_____

Did any part of your body strike any part of the vehicle during the accident? ☐ Yes ☐ No

Describe:_____

_____

What is the estimated property damage to your vehicle? _____

Estimated damage to other vehicle ☐ None ☐ Minimal ☐ Moderate ☐ Major

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

Were the police notified? ☐ Yes ☐ No

In your own words, please describe the accident: _____

_____

_____

Did you have any physical complaints BEFORE THE ACCIDENT? ☐ Yes ☐ No If yes , please describe in detail:

_____

_____

Please describe how you felt immediately after the accident: _____

_____

Were you taken to the hospital? ☐ Yes ☐ No If so, which one? _____

Have you been treated by another Doctor/hospital since the accident? ☐ Yes ☐ No If yes, list Doctors/Hospital:

_____

What type of treatment did you receive? _____

_____

Medications: _____

Since your injury occurred, are your symptoms: ☐ Improving ☐ Getting worse ☐ Same

CHECK THE SYMPTOMS YOU HAVE NOTICED SINCE INCIDENT:

☐ Headache	☐ Irritability	☐ Numbness in Toes	☐ Face Flushed	☐ Feet Cold
☐ Neck Pain	☐ Chest Pain	☐ Shortness of Breath	☐ Buzzing in Ears	☐ Hands Cold
☐ Neck Stiff	☐ Dizziness	☐ Jaw pain/Popping/Grinding	☐ Loss of Balance	☐ Fatigue
☐ Difficulty Sleeping	☐ Depression	☐ Head Seems Too Heavy	☐ Fainting	☐ Constipation
☐ Back Pain	☐ Cold Sweats	☐ Pins & Needles in Arms	☐ Light Bother Eyes	☐ Loss of Smell
☐ Nervousness	☐ Loss of Memory	☐ Pins & Needles in Legs	☐ Loss of Taste	☐ Fever
☐ Tension	☐ Ears Ring	☐ Numbness in Fingers	☐ Stomach Upset	☐ Diarrhea

Symptoms other than above: _____

Have you lost time from work as a result of this accident? ☐ Yes ☐ No If yes, Please explain:

_____

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

_____

_____

Date: _____ Patient's Signature: _____

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PAST OR PRESENT SYMPTOMS, CONDITIONS OR HABITS

Below is a listing of symptoms, conditions or habits. Please check the box indicating whether this applies to past or present.

Symptom	Past	Present	Symptom	Past	Present
Neck Pain	❑	❑	High Blood Pressure	❑	❑
Shoulder Pain	❑	❑	Heart Condition	❑	❑
Arm/Elbow Pain	❑	❑	Respiratory Condition	❑	❑
Hand Pain	❑	❑	Digestive Problems	❑	❑
Upper Back Pain	❑	❑	Kidney/Bladder Problems	❑	❑
Lower Back Pain	❑	❑	Menstrual Problems	❑	❑
Pain in Upper Leg or Hip	❑	❑	Breast Soreness/Lump	❑	❑
Pain in Lower Leg or Knee	❑	❑	Sinus Conditions	❑	❑
Pain in Ankle or Foot	❑	❑	Allergies/Asthma	❑	❑
Numbness/Tingling in Arms or Legs	❑	❑	Cancer	❑	❑
Jaw Pain	❑	❑	Stroke	❑	❑
Swelling/Stiffness of Joints	❑	❑	Excessive Weight Loss/Gain	❑	❑
Headaches	❑	❑	Skin Condition	❑	❑
Dizziness	❑	❑	Arthritis	❑	❑
Fainting Spells	❑	❑	Diabetes	❑	❑
Convulsions	❑	❑	Prostate Condition	❑	❑
General Prolonged Fatigue	❑	❑	Constipation/Diarrhea	❑	❑
Condition of Uterus/Ovaries	❑	❑	Pregnancy	❑	❑

Tobacco Use:

❑ Past ❑ Present

❑ Occasional ❑ Moderate ❑ Heavy

Alcohol Use:

❑ Past ❑ Present

❑ Occasional ❑ Moderate ❑ Heavy

Please list any medications or nutritional supplements you take:

_____

_____

_____

_____

_____

_____

_____

_____

INJURIES, ACCIDENTS AND SURGERIES

Please list the description and date of any injuries, accidents or surgeries you have had.

Broken Bones _____

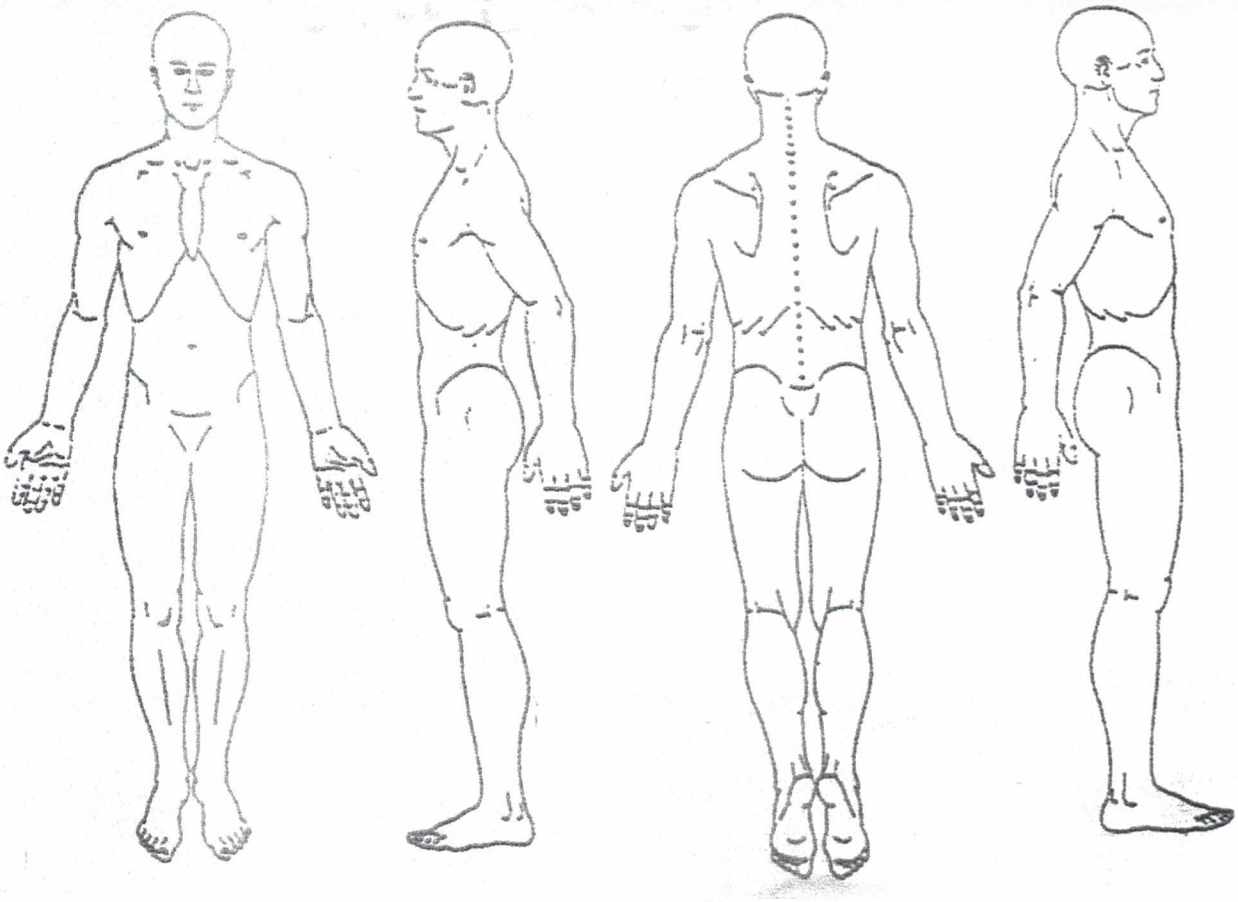
Falls _____

Surgeries _____

Automobile Accidents _____

Work Injuries _____

Other _____



TYPE OF PAIN YOU ARE CURRENTLY EXPERIENCING...

Place appropriate symbol or letter on the diagram.

Ache = AAAAA Numbness = NNNNN Pins and Needles = OOOOO

Burning = XXXXX Stabbing = /////

Please place a mark on the line that corresponds to your **current** pain level.

NO PAIN WORSE PAIN POSSIBLE

Patient Name_____Date_____

Doctors Notes

_____

_____

_____

_____