Chart#_____

BAKKE CHIROPRACTIC

Personal Injury History Form

Patient Information

Last Name: _____ First Name: _____ M.I.: _____

Social Security #: _____-_____-_____ Date of Injury: _____ Time of Injury: _____ AM/PM

Accident Details

Location of accident: _____

Explain how the injury happened (be specific): _____

_____

Were you cut or bruised? No _____ Yes _____ If yes, please describe: _____

_____

Were you knocked unconscious? No _____ Yes _____ Was a police report done? No _____ Yes _____

Did the ambulance come? No _____ Yes _____ If yes, were you evaluated by them? No _____ Yes _____

Describe specifically how you felt **IMMEDIATELY** after the accident: _____

_____

Later that day: _____

Next day: _____

Did you seek any treatment prior to today because of the injury? No _____ Yes _____ If yes, please explain: _____

_____

Are you currently on any work restrictions? No _____ Yes _____ If yes, please explain: _____

_____

Prior to this incident have you ever been injured/ or had symptoms in the area now affected? No _____ Yes _____

If yes, please explain (be specific): _____

Are your daily activities different since this injury? No _____ Yes _____ If yes, please explain: _____

_____

Did you report the injury? No _____ Yes _____

Did you fill out an injury report and turn it in? No _____Yes _____

Contact Person Name: _____ Phone #: _____

Do you have an attorney? No _____ Yes _____

If yes, Attorney Name: _____ Attorney Phone #: _____

Patient/ Guardian Signature: _____ **Date:** _____

Office Use Only

Insurance Carrier: _____ Adjustor Name: _____

Claims Address: _____ Adjustor Phone #: _____

_____ Claim Number: _____

Bakke
Chiropractic Clinic

312 East North Street
DeForest, WI 53532
608/846-3333
608/846-7033 fax

725 West Main Street
Suite A
Sun Prairie, WI 53590
608/837-7600
608/837-0633 fax

612 East Main Street
Waunakee, WI 53597
608/849-9014
608/849-9015 fax

801 North Main Street
Lodi, WI 53555
608/592-1400
608/592-3063 fax

Insurance Company:

RE: Health Reports and Doctor's Lien For Direct Payment

I hereby authorize the above captioned doctor to furnish you, my Insurance Company and/or the Insurance Company representing the liable party, with a full report of examination, diagnosis, treatment, prognosis, etc., of myself in regard to the accident in which I was involved.

I hereby authorize and direct you, my Insurance Company and/or the Insurance Company representing the liable party, to pay directly to said doctor such sums as may be due and owing him for professional services rendered me both by reason of this accident and by reason of any other bills that are due his office and to withhold such sums from any settlement, judgment of verdict as may be necessary to adequately protect said doctor. I hereby further give a lien on my case to said doctor against any and all proceeds of any settlement, judgment or verdict which may be paid to you, my Insurance Company and/or the Insurance Company representing the liable party, or myself as the result of the injuries for which I have been treated or injuries in connection therewith.

I fully understand that I am directly and fully responsible to said doctor for all professional bills submitted by him for service rendered me and that this agreement is made solely for said doctor's additional protection and in consideration of his awaiting payment. And I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee.

Dated: _____ Patient's Signature: _____

<u>If patient is a minor:</u>

Signature of Parent/Guardian: _____

Relationship to Patient: _____

The undersigned being the Insurance Company of record for the above patient does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgment of verdict as may be necessary to adequately protect the said doctor named above.

Dated: _____ Insurance Representative: _____