Soma
WELLNESS
A Center for Extraordinary Health

3333 Denali Street Suite 150
Anchorage, Ak 99503
Phone 907-563-SOMA (7662)
Fax 907-562-SOMA (7662)
www.SomaWellnessAk.com
dramyconklin@gmail.com

## Personal Injury Patient

- We **MUST** have:
  - Standard **New Patient** paperwork completed, that will be given to you by Soma Wellness office staff.
  - **Personal Auto Insurance Company Name**
  - **Claim Number**
  - **Adjuster Name and Telephone Number**
  - **Verification of Med Pay Prior to Treatment**

Please contact your auto insurance company to verify if you have **MED PAY** on your plan and the maximum amount that is allowed for medical payments. If your plan **does not have med pay, we will expect payment in full at time of service. We do not bill third party insurance.** We will provide you with receipts and chart notes if needed so you may bill third party insurance for your reimbursement.

# PERSONAL INJURY INFORMATION

Patient Name: _____ Date _____

## LIABLE PARTY'S INFORMATION

Name: _____

Group Name: _____ Group Number: _____

Policy number _____ Case number _____

Address _____

## PATIENT INSURANCE INFORMATION

Insurance name _____

Group Number: _____ Policy Number _____

Phone _____ Agent Name _____

Address _____

## PLEASE INCULDE A COPY OF THE POLICE REPORT

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# IRREVOCABLE DOCTOR'S LIEN AND MEDICAL AUTHORIZATION

ATTORNEY'S NAME: _____ PHONE: _____

ATTORNEY'S ADDRESS: _____

ATTORNEY'S CITY/STATE/ZIP: _____

INSURANCE NAME: _____ PHONE: _____

INSURANCE ADDRESS: _____

INSURANCE CITY/STATE/ZIP: _____

I hereby authorize the above doctor to furnish you, my attorney and/or the auto liability, medical pay or group insurance carrier, with a full report of my physician's examination, diagnosis, treatment, prognosis, itemized billing statements, etc., of myself in regards to the accident in which I was involved.

I hereby authorize and direct you, my attorney and/or the auto liability, medical pay or group insurance carrier, 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, judgement, or 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, judgement or verdict which may be paid to you, my attorney and/or the auto liability, medical pay or group insurance carrier, 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 services 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, judgement or verdict by which I may eventually recover said fee.

Patient's Printed Name: _____

Patient's Signature: _____ Date: _____

# Automobile Accident Questionnaire

**Please answer all questions completely!**

In order for us to understand your condition properly, please be as neat and accurate as possible while completing this form.

***PLEASE ANSWER ALL QUESTIONS PRECEDED BY ASTERICKS.**

PATIENT NAME:_____SOCIAL SEC. #_____TODAY'S DATE_____

ADDRESS_____ City_____ State____ ZIP code_____ HM #_____

AGE_____ DOB_____ [ ] M [ ] F MARITAL STATUS_____ AGES OF CHILDREN_____ DRIVER'S LIC. # _____

OCCUPATION_____ [ ] FULL TIME [ ] PART TIME WK # _____EXT._____

EMPLOYER_____ LOCATION/ADDRESS_____

SPOUSE'S NAME_____ SPOUSE'S SS#_____ SPOUSE'S EMPLOYER_____LOCATION_____

**********

**DATE OF ACCIDENT:** DAY___ MONTH_____ YEAR _____TIME OF ACCIDENT [ ] AM [ ] PM CITY _____

**LOCATION:** You were heading [ ] North [ ] South [ ] East [ ] West on _____(St./Ave/Hwy) at _____mph

Other Vehicle was headed [ ] North [ ] South [ ] East [ ] West on _____(St./Ave/Hwy) at _____mph

**VEHICLES INVOLVED:** Your vehicle was a 19_____ / 20____ Make_____Other vehicle_____

**YOUR LOCATION IN THE CAR:** You were [ ] Driver [ ] Passenger [ ] Front seat [ ] Right rear [ ] Left rear [ ] Pedestrian

Were you using Seat Belts? [ ] Yes [ ] No Shoulder Strap? [ ] Yes [ ] No Head Rest? [ ] Yes [ ] No

At time of impact, your were looking: [ ] forward [ ] right [ ] left Your body was facing: [ ] Forward [ ] Right [ ] Left

Were both hands on the wheel? [ ] Yes [ ] No Was your foot on the brake? [ ] Yes [ ] No How far did you skid?_____

Where in the car were you after the accident?_____Could you walk afterwards_____

How many others were in your car?_____ How many others were in other vehicle? _____ Were there any fatalities?_____

**THE IMPACT:** Your car was struck by another vehicle another vehicle? [ ] Yes [ ] No Your car struck other vehicle/objects?_____

Impact was from: [ ] Behind [ ] Right Rear [ ] Left Rear [ ] Right side [ ] Left side [ ] Front [ ] Right front [ ] Left front

Impact occurred: [ ] with warning [ ] without warning You were braced for impact? [ ] Y [ ] N How?_____

Did you feel any popping, tearing or ripping noise in your neck or back?_____

Did you feel any pain right at the moment of impact? [ ] Yes [ ] No Where?_____

If no immediate pain, how long until you felt any symptoms?_____What symptoms?_____

Were you knocked unconscious?_____ How long?_____ Dazed?_____ Stunned?_____ How long?_____

Did you strike any part of the car during the accident? [ ] Yes [ ] No What?_____

What body parts received this impact?_____Any Bruises?_____

**DESCRIBE THE ACCIDENT IN YOUR OWN WORDS**_____

_____

_____

State the road, visibility and weather conditions:_____

Was the accident reported to the police?_____ Where any traffic citations issued? _____ To whom?_____

Was your vehicle drivable after the accident? _____Other vehicle?_____Did you drive your car home?_____

**YOUR PRESENT COMPLAINTS DUE TO THIS ACCIDENT ARE:**_____

_____

Are your pains: [ ] constant [ ] on and off [ ] worse at times [ ] improving [ ] getting worse [ ] staying the same

Is it painful to move your head? [ ] Right [ ] Left [ ] Downward [ ] Backward [ ] when rising from a lying position

Is it painful to bend your trunk? [ ] Right [ ] Left [ ] Forward [ ] Backward To turn your trunk [ ] Right [ ] Left

What positions are comfortable? Lying on your: [ ] Back [ ] Right side [ ] Left side [ ] Stomach [ ] Sitting [ ] Standing

What positions, movements or activities cause discomfort?_____

Do any of the following give any relief? [ ] Ice pack [ ] Heating pad [ ] Hot bath/shower [ ] Stretching [ ] Brace/ Collar

**(PLEASE TURN OVER AND COMPLETE THE BACK)**

**TREATMENT FOR THESE SYMPTOMS:**

What treatment or assistance did you receive at the accident site?_____

Did you go to the hospital? [ ] Yes [ ] No When? [ ] Straight from the accident [ ] later same day [ ] next day_____

Name of hospital:_____ How did you get there? [ ] ambulance [ ] private vehicle

Did the ambulance attendants utilize: [ ] neck collar [ ] splints [ ] brace

Were you admitted to the hospital? [ ] Yes [ ] No How long did you stay?_____

Attending doctor?_____ What tests were done? [ ] x-rays [ ] blood [ ] urine

What was the diagnosis?_____ What recommendations were made?_____

What treatment was given?_____

Has any other doctor been seen relative to this accident? Dr._____ [ ] OC [ ] DO [ ] MD

Diagnosis_____ Recommendations_____

Treatment_____How often did you see this doctor?_____How long?_____

What surgery recommended? [ ] Yes [ ] No Was surgery performed? [ ] Yes [ ] No

Results of care: (good, fair, ineffective, percent relief):_____

Are you currently under care or taking medications for this?_____

What home care have you tried? (such as rest, aspirin, heat)_____

**WORK / ACTIVITY STATUS:** Before the injury, were you capable of working on an equal basis with others your age? [ ] Yes [ ] No

Are your work activities restricted due to this accident? [ ] Yes [ ] No Are you able to work?_____Are you working?_____

What other activities does this injury interfere with?_____

Have you lost any time from work due to this accident? [ ] Yes [ ] No From_____To_____

Totally Disabled from_____ To _____ Partially Disabled From_____to_____

**PRIOR COMPLAINTS:** Have you ever had any complaints in the involved area before? [ ] Yes [ ] No If so, when?_____

What were the complaints:_____

What occurred:_____

What treatment was given:_____Was recovery complete? [ ] Yes [ ] No

Were claims filed [ ] Yes [ ] No State any disability awarded?_____ Any military disability? [ ] Yes [ ] No

What prior problems still existed at the time of this accident?_____

Since this injury, have there been any traumas, injuries or aggravations?_____

FEMALE: Were you pregnant at the time of this accident? [ ] Yes [ ] No Are you pregnant now? [ ] Yes [ ] No

Have you received any chiropractic care before? [ ] Yes [ ] No When?_____ Length of care:_____

Condition treated:_____Results of care: Good Fair Poor Other_____

Name and location of doctor_____X-rays taken? [ ] Yes [ ] No

**INSURANCE DATA:** Has your insurance company been notified? [ ] Yes [ ] No Have you filed an accident (PIP) form with them? [ ] Yes [ ] No

Name of your insurance company_____Policy No._____

Name of your insurance agent_____Claim No._____

Drive of vehicle in which your were injured (if not yourself)_____

His / Her insurance company_____Policy No._____

Driver of other vehicle_____Insurance Co._____Policy No._____

Have you been contacted by an insurance adjustor regarding this claim? [ ] Yes [ ] No Name:_____

Have you retained an attorney? [ ] Yes [ ] No Your Attorney's Name_____

Do you feel you may need an attorney? [ ] Yes [ ] No City_____Phone_____

_____

Patient's Signature

----------**DO NOT WRITE BELOW THIS LINE**----------