1500 Oglethorpe Ave Suite 2400 Athens, GA 30606
Phone: 470-339-0200 Fax: 678-280-6769

Name_____Age_____Date_____

Address _____City _____State _____ Zip _____

Male / Female Date of Birth _____ SS#_____ Email_____

Home Phone _____Cell Phone_____ Work Phone_____

Primary Care Doctor_____

Referring Physician_____Phone_____

Employer_____ Occupation _____

Business Address_____ City_____State_____ Zip _____

Health Insurance Company_____ID#_____Group#_____

Spouse_____ Spouse's Employer _____

Emergency Contact_____Relationship_____ Phone_____

Is your problem today the result of Workers Comp _____Yes _____No _____
If yes, what is the name of the caseworker? _____ _Name of Workers Comp Co._____
Phone_____ Claim No_____ Date of Injury_____

Is your problem today from the result of Auto Accident _____Yes _____No _____Date of Accident _____
Name of Automobile Insurance Carrier_____ Phone No._____
Adjustor Name_____ Claim No._____
Medpay Limit $_____ How much has been used? _____

Attorney name and Phone number_____

I authorize the release of any medical information necessary to process my insurance claim. I hereby authorize payment to be made to Trident Medical Centers, PC . I understand any unpaid balance is my financial obligation. As a courtesy, we bill your insurance directly, however the insurance and or settlement checks may be sent to you, made out in your name. I agree to bring these checks to Trident Medical Centers, PC I agree not to tear apart the check from the explanation of benefits. If I fail to bring payments received from my insurance company or settlement within three business days of receipt, I will be responsible for the entire amount billed.

_____ _____

Patients Signature Date **Witness Signature Date**

TRIDENT MEDICAL CENTERS
AUTOMOBILE INJURY QUESTIONAIRE

1. What was the date of the accident? _____

2. What time did the accident occur? _____

3. How many vehicles were involved in the accident? _____

4. What was the estimated damage to the vehicle you were in? _____

5. What state did the accident occur in? _____

6. What city did the accident occur in? _____

7. What street or intersection were you on when the accident occurred? _____

8. What direction were you traveling in? _____

9. What type of impact was the auto accident? _____

10. Did your vehicle hit anything after the accident? If yes, please describe
_____

11. Where were you sitting in the vehicle during the accident? _____

12. Did you know the accident was coming? _____

13. What type of vehicle were you in? _____

14. What type of vehicle impacted yours? _____

15. At the time of the impact, how fast was your vehicle moving? _____

16. At the time of impact, how fast was the other vehicle moving? _____

17. During and after the crash what happened to your vehicle? (Circle all that apply)

- Kept going straight
- Kept going straight hitting a car in front
- Was hit by another vehicle
- spun around
- spun around and hit a stationary object
- hit a stationary object

18. Did you lose consciousness during the accident? -Yes - no

19. How was your head positioned during the accident? _____

20. How was your torso positioned during the accident? _____

21. How were your hands positioned during the accident? _____

22. Did your head hit anything during the accident? -No - yes, please describe_____

23. Did your face hit anything during the accident? -No - yes, please describe_____

24. Did your shoulders hit anything during the accident? -No - yes, please describe_____

25. Did your neck hit anything during the accident? -No - yes, please describe_____

26. Did your chest hit anything during the accident? -No - yes, please describe_____

27. Did your hips hit anything during the accident? -No - yes, please describe_____

28. Did your knees hit anything during the accident? -No - yes, please describe_____

29. Did your feet hit anything during the accident? -No - yes, please describe_____

30. What kind of headrest was in your vehicle?
- Movable fixed headrest
- Non-movable fixed headrest
- No headrest

31. Where was the headrest positioned on your head? _____

32. Did you have your seatbelt on during the accident? - Yes -no

33. Did you slide out of your seatbelt during the accident? _____

34. What was damaged in your vehicle? (Circle all that apply)

- Windshield	- rear bumper	- mirror
- Steering wheel	- front bumper	- knee bolster
- Dashboard	- trunk	- back right door
- Seat frame	- front left door	- completely totaled
- Side window	- front right door	
- Rear window	- back left door	

35. Choose the items that dented inward
- Floorboards - side door - dashboard

36. Choose the doors that would not open as a result of the accident
- Front left - front right
- Rear left - rear right

37. Did you go to the hospital? If no, why and do not answer 38-43
_____

38. How did get to the hospital? _____

39. What was the name of the hospital? _____

40. Were you hospitalized overnight? _____

41. Circle what you were prescribed at the hospital
- Pain medication - muscle relaxers - neck brace

42. Did you receive any stitches for any cuts at the hospital? _____

43. Were x rays taken at the hospital? If yes, which area was taken?
_____

X-Ray Pregnancy Disclaimer

(Please check one)
I certify that _____ I am or _____ am not pregnant due to the best of my knowledge. I have been advised that receiving X-Rays during pregnancy could cause potential risks to the unborn child including birth defects.

Patient Signature_____ Date:_____

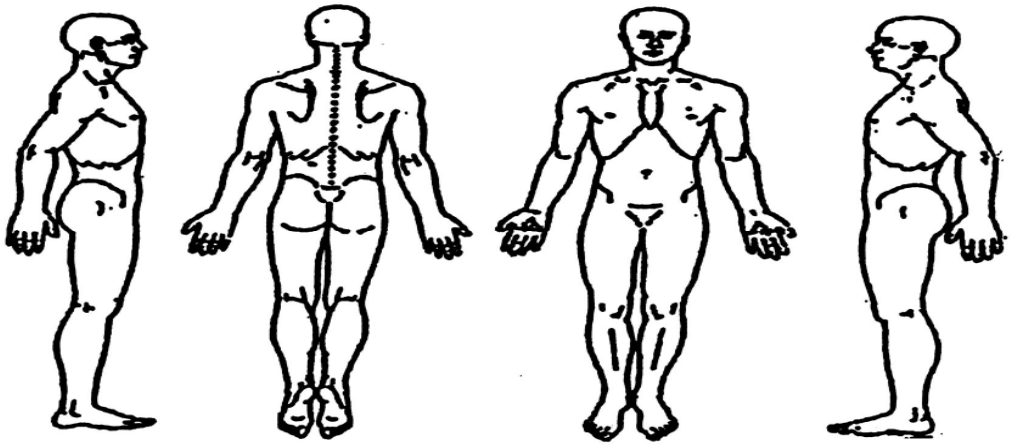
TRIDENT
MEDICAL CENTERS, PC.

Patient Name: _____ Date: _____

Height_____ **Weight**_____**Age**_____

Is today's problem caused by: □ Auto Accident □ Workman's Compensation □ Other

Indicate on the drawings below where you have pain/symptoms. Number them in order of severity 1-10. 1 being the problem that hurts you the most.



How often do you experience your symptoms?

□ Constantly (76-100% of the time) □ Occasionally (26-50% of the time)
□ Frequently (51-75% of the time) □ Intermittently (1-25% of the time)

How would you describe the type of pain?

□ Sharp □ Numb
□ Dull □ Tingly
□ Diffuse □ Sharp with motion
□ Achy □ Shooting with motion
□ Burning □ Stabbing with motion
□ Shooting □ Electric like with motion
□ Stiff □ Other:_____

How are your symptoms changing with time?

□ Getting Worse □ Staying the Same □ Getting Better

Using a scale from 0-10 (10 being the worst), how would you rate each of your problems?

Problem #1.	0	1	2	3	4	5	6	7	8	9	10 (*Please circle*)
Problem #2.	0	1	2	3	4	5	6	7	8	9	10 (*Please circle*)
Problem #3.	0	1	2	3	4	5	6	7	8	9	10 (*Please circle*)
Problem #4.	0	1	2	3	4	5	6	7	8	9	10 (*Please circle*)
Problem #5.	0	1	2	3	4	5	6	7	8	9	10 (*Please circle*)
Problem #6.	0	1	2	3	4	5	6	7	8	9	10 (*Please circle*)

How much has the problem interfered with your work?

□ Not at all □ A little bit □ Moderately □ Quite a bit □ Extremely

How much has the problem interfered with your social activities?

□ Not at all □ A little bit □ Moderately Quite a bit □ Extremely

Who else have you seen for your problem?

□ Chiropractor □ Neurologist □ Primary Care Physician
□ ER physician □ Orthopedist □ Other:_____
□ Massage Therapist □ Physical Therapist □ No one

How long have you had this problem? _____

How do you think your problem began?_____

12. Do you consider this problem to be severe?
□ Yes □ Yes, at times □ No

13. What aggravates your problem? What makes you problem better?

_____

14. What concerns you the most about your problem; what does it prevent you from doing?

_____

16. How would you rate your overall Health?
□ Excellent □ Very Good □ Good □ Fair □ Poor

17. What type of exercise do you do?
□ Strenuous □ Moderate □ Light □ None

18. Indicate if you have any immediate family members with any of the following:
□ Rheumatoid Arthritis □ Diabetes □ Lupus □Auto Immune Disorder
□ Heart Problems □ Cancer □ ALS □ Lung Problems

19. For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" column.

Past	Present	Past	Present	Past	Present
□	□ Headaches	□	□ High Blood Pressure	□	□ Diabetes
□	□ Neck Pain	□	□ Heart Attack	□	□ Excessive Thirst
□	□ Upper Back Pain	□	□ Chest Pains	□	□ Frequent Urination
□	□ Mid Back Pain	□	□ Stroke	□	□ Smoking/Tobacco Use
□	□ Low Back Pain	□	□ Angina	□	□ Drug/Alcohol Dependance
□	□ Shoulder Pain	□	□ Kidney Stones	□	□ Allergies
□	□ Elbow/Upper Arm Pain	□	□ Kidney Disorders	□	□ Depression
□	□ Wrist Pain	□	□ Bladder Infection	□	□ Systemic Lupus
□	□ Hand Pain	□	□ Painful Urination	□	□ Epilepsy
□	□ Hip Pain	□	□ Loss of Bladder Control	□	□ Dermatitis/Eczema/Rash
□	□ Upper Leg Pain	□	□ Prostate Problems	□	□ HIV/AIDS
□	□ Knee Pain	□	□ Abnormal Weight Gain/Loss		
□	□ Ankle/Foot Pain	□	□ Loss of Appetite	**For Females Only**	
□	□ Jaw Pain	□	□ Abdominal Pain	□	□ Birth Control Pills
□	□ Joint Pain/Stiffness	□	□ Ulcer	□	□ Hormonal Replacement
□	□ Arthritis	□	□ Hepatitis	□	□ Pregnancy
□	□ Rheumatoid Arthritis	□	□ Liver/Gall Bladder Disorder		
□	□ Cancer	□	□ General Fatigue		
□	□ Tumor	□	□ Muscular Incoordination		
□	□ Asthma	□	□ Visual Disturbances		
□	□ Chronic Sinusitis	□	□ Dizziness		
□	□ Other:_____				

Please list all Allergies _____

20. List all prescription medications you are currently taking:

_____

21. List all of the over-the-counter medications you are currently taking:

_____

22. List all surgical procedures you have had:

_____

23. What activities do you do at work?

□ **Sit:**	□ Most of the day	□ Half the day	□ A little of the day
□ **Stand:**	□ Most of the day	□ Half the day	□ A little of the day
□ **Computer work:**	□ Most of the day	□ Half the day	□ A little of the day
□ **On the phone:**	□ Most of the day	□ Half of the day	□ A little of the day

24. What activities do you do outside of work?

_____

25. Have you ever been hospitalized? □ No □ Yes
if yes, why _____

26. Have you had significant past trauma? □ No □ Yes

27. Anything else pertinent to your visit today?_____

Patient Signature_____ **Date:**_____

1500 Oglethorpe Ave. Suite 2400 Athens, GA 30606

Phone: 470-339-0200 Fax: 678-280-6769

MEDICAL RECORDS REQUEST

DATE: _____

TO:_____

_____

_____

I, _____ hereby request that my complete medical records be released to Trident Medical Centers, PC.

I understand that this authorization allows the release of all information in my medical records to include lab test results, x-rays, and any surgery information. This authorization allows such record to be mailed or faxed. I understand that I may revoke this consent at any time. This consent will automatically expire without my expressed revocation 90 days from the date on this form.

PATIENT NAME: _____

PATIENT ADDRESS: _____

PATIENT DOB: _____

PATIENT/GUARDIAN SIGNATURE: _____

Mailing Address:

2133 Hwy 317 #12-345 Suwanee, GA 30024

TRIDENT MEDICAL CENTERS, P.C.

AUTHORIZATIONS & RELEASES / FINANCIAL POLICY/LIEN FOR MEDICAL SERVICES

Patient _____ **Date of Loss/Injury** _____ **Attorney** _____

Consent for Treatment

_____ Initial

I, the undersigned, hereby authorize the Doctors of Trident Medical Centers, P.C. and whomever they may designate as their assistant(s), to perform evaluations, diagnostic tests and to administer treatment as is necessary. I also certify that no guarantee or assurance has been made as to the results that may occur as a result of this treatment.

Consent for Treatment of Minor

_____ Initial

I, the undersigned, hereby authorize the doctors of Trident Medical Centers, P.C. and whomever they may designate as their assistant(s), to perform evaluations, diagnostic tests and to administer treatment as is necessary to my child (Child's Name) _____ of which I am the legal guardian.

Certification, Authorization and Release in Accordance with HIPPA

_____ Initial

I authorize the release of any medical information necessary to process my insurance claim(s) and also certify that all insurance and accident information given by me to Trident Medical Centers, P.C. is correct and complete. I understand that my medical information, relating to this personal injury case, may be shared to manage and expedite my medical treatment. I authorize my treating physician(s) and Trident Medical Centers, P.C., to secure, release and disclose medical treatment information only with companies, individuals, and any necessary parties involved in my case.

Request for Payment of Benefits to Provider or Care

_____ Initial

I hereby authorize my Insurance company/Insurance Administrator to pay by check and for it to be mailed directly to Trident Medical Centers, P.C., any benefits allowable, and otherwise payable to me under my current policy, as payment toward the total charges for professional services rendered. I understand that Trident Medical Centers, P.C. is a separate and distinct medical provider and attorney and/or Insurance company will receive separate bills for service and statements for services provided by the doctors or their assistant(s) of Trident Medical Centers, P.C.

Attorney Representation and Protection of Balance

_____ Initial

I authorize and direct my attorney,_____ to pay directly to Trident Medical Centers, P.C. for services rendered to me and/or my children and withhold such sums from my portion of any settlement, claim judgments or jury verdict. I fully understand that I am responsible for all medical bills and this agreement is made in consideration for Trident Medical Center's agreement to forgo immediate payment, by me, for such medical services at the time those services were rendered. I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee.

Payment Policy

_____ Initial

Trident Medical Centers, P.C. expect to be paid by the first available means whether by health insurance, your Auto Medical Payments, or settlement of your cases. It is the policy of Trident Medical Centers, P.C., to file all available applicable insurance on an accidental injury patient including: Health Insurance: Proof of insurance must be provided in order for us to file claims with your insurance company. Please understand that benefits through health insurance policies differ. Insurance companies pay according to your individual policy limits. Benefits are between you and your insurance carrier. Any discrepancies with your benefit coverage must be handled by you and your insurance provider. Any portion of your medical bills that are not covered by your insurance will be included in your statement sent to your attorney and paid once your case settles. Auto Insurance: Trident Medical Centers, P.C. does not file against the third party insurance. If there is MED PAY on your policy or on the policy of the car you were a passenger in, Trident Medical Centers, PC will submit to that carrier. If there are medical benefits available there may be a maximum allowable amount of coverage, which may not cover all charges in full. Any portion of your medical bills that are not covered by your health insurance or Med Pay coverage will be included in your statement sent to your attorney and paid once your case settles.

I understand, agree to and will abide by all of the above. I will cooperate in processing this accident claim. I fully understand and acknowledge that I am responsible for all medical charges incurred by me for services provided by Trident Medical Centers, P.C.

_____	_____	_____
PATIENT NAME	**PATIENT SIGNATURE**	**DATE**
_____	_____	_____
ATTORNEY NAME	**ATTORNEY SIGNATURE**	**DATE**

_____
WITNESS

TRIDENT MEDICAL CENTERS, P.C
1500 Oglethorpe Ave., SUITE 2400, ATHENS, GA 30606
470-339-0200 Fax 678-280-6769

Phone: 470-339-0200 Fax: 678-280-6769

Pain Medication and Prescription Refill Policy

1. I agree to allow 48 hours for prescription refills.
2. I understand that prescription refills requested after 4:00 pm will not be received until the next business day.
3. I understand that a follow-up visit may be required from my physician in order to obtain a refill.
4. I agree to take all medications exactly as instructed. I am NOT allowed to change the dosage amounts
5. Narcotics and non-narcotic medications will not be phoned in after hours or on weekends.
6. Patients may be terminated from the practice for noncompliance in the taking of their medications.
7. Precision Healthcare will NOT refill prescriptions that have been lost or misplaced.
8. I MUST keep all appointments as recommended.
9. I will not give, trade, or sell medications.
10. The following are also conditions for immediate termination from practice:
    - Obtaining narcotics from any other physician while under the care of Precision Healthcare. This is a felony in Georgia (“doctor shopping”) and will be reported.
    - Altering or forging a prescription. This is a felony and will be reported.
11. I am aware that most of the manufactures of drugs used to treat pain recommend against the operation of heavy equipment, which includes driving a motor vehicle. I understand that if I choose to drive a vehicle while taking pain medication, I could be charged with a DUI.
12. I will not combine narcotic medications with the consumption of alcohol.
13. Only one pharmacy may be used for filling prescriptions.

I have read, understood and agree to the policies above. I understand that if I do not sign this document, my physician may refuse to prescribe me medications.

Patient Name (Printed):_____

Patient Signature: _____Date:_____