PERSONAL INJURY PROTECTION INFORMATION

First Name _____Last Name _____Date of birth_____

INSURANCE COMPANY: _____ PHONE #: _____

ADDRESS: _____ CITY: _____ ST: _____ ZIP: _____

Was this accident reported to your insurance company? ( ) yes ( ) No If no, please do this today

Do you have a Police Report ( ) yes* No ( ) *Please provide a copy

CLAIM #: _____ POLICY #: _____

ADJUSTER Name: _____ PHONE #: _____ EXT: _____

INSURED: ( ) SELF ( ) SPOUSE* ( ) CHILD ( ) OTHER*_____

*If the insured is other than self, please complete below

INSURED INFORMATION

FULL NAME: _____ _____

Last First

ADDRESS: _____ CITY: _____ ST: _____ ZIP: _____

PHONE #: _____ DOB: _____ SS#: _____

SECOND INSURANCE COMPANY: _____ PHONE #: _____

ADDRESS: _____ CITY: _____ ST: _____ ZIP: _____

CLAIM #: _____ POLICY #: _____

Have you signed with an Attorney? ( ) yes * ( ) No *If yes complete de following information

ATTORNEY FIRM/FULL MAME _____

ADDRESS: _____ CITY: _____ ST: _____ ZIP: _____

PHONE #: _____ FAX #: _____

2500 E. Commercial Blvd. Suite D. - Fort Lauderdale, Florida 33308
Phone: (954) 909-5708 Fax: (954) 909-5709 admin@prontouc.com frontdesk@prontouc.com

First Name _____Last Name _____Date of birth_____

AUTOMOBILE ACCIDENT QUESTIONAIRE

What is the date and time of the accident? _____
Date Time

Which direction were you heading? ( ) North ( ) South ( ) East ( ) West
On what street or intersection? _____

Which direction was the other person heading? ( ) North ( ) South ( ) East ( ) West
On what street or intersection? _____

Were the police notified? ( ) Yes ( ) No - Who was cited? _____

Were you knocked unconscious? ( ) Yes ( ) No

Were you struck from: ( ) behind ( ) front ( ) left side ( ) right side

Were you the: ( ) driver ( ) front passenger ( ) back street, driver side
( ) back seat, passenger side ( ) other: _____

Did you feel pain immediately after the accident? ( ) yes ( ) No

If yes, please explain: _____

_____

Were you wearing your seat belt? ( ) Yes ( ) No Did the airbag deploy? ( ) Yes ( ) No

Were you looking straight ahead at impact? ( ) yes ( ) No

If No, please explain: _____

Are you presently able to work? ( ) Yes ( ) No

Please list all of your complaints/Injuries: _____ , _____

_____ , _____, _____

Have you ever had these complaints before? ( ) Yes ( ) No
If yes, please explain: _____

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GENERAL SYMPTOM SURVEY

HEADACHES:

MILD MODERATE SEVERE 1 2 3 4 5 6 7 8 9 10 (10= SEVERE)

Description of pain: ( ) Sharp ( ) Dull ( ) Throb ( ) Ache ( ) Pressure

Location: ( ) Front ( ) Rt side ( ) Lt side ( ) Back ( ) Top ( ) Behind eyes

Duration: ( ) Constant ( ) Off and on How often? _____ times per ( ) Day ( ) Week

****

NECK:

MILD MODERATE SEVERE 1 2 3 4 5 6 7 8 9 10 (10= SEVERE) MILD

( ) Stiff/tight ( ) Ache/sore ( ) Sharp ( ) Burn ( ) Throb ( ) Tingling ( ) Dull

Location: ( ) Rt side ( ) Lt side ( ) Both Duration: ( ) Constant ( ) Off/on

Pain/tingling/numbness: ( ) Rt shoulder ( ) Rt forearm ( ) Rt hand ( ) Rt fingers
( ) Lt shoulder ( ) Lt forearm ( ) Lt hand ( ) Lt fingers

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MID-BACK:

MILD MODERATE SEVERE 1 2 3 4 5 6 7 8 9 10 (10= SEVERE)

( ) Stiff/tight ( ) Ache/sore ( ) Sharp ( ) Burn ( ) Throb ( ) Tingling ( ) Dull

Location: ( ) Rt side ( ) Lt side ( ) Both Duration: ( ) Constant ( ) Off/on

Pain/tingling/numbness: ( ) Rt thigh ( ) Rt knee ( ) Rt calf ( ) Rt foot ( ) Rt toes
( ) Lt thigh ( ) Lt knee ( ) Lt calf ( ) Lt foot ( ) Lt toes

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HIPS/BUTTOCKS:

MILD MODERATE SEVERE 1 2 3 4 5 6 7 8 9 10 (10= SEVERE)

( ) Stiff/tight ( ) Ache/sore ( ) Sharp ( ) Burn ( ) Throb ( ) Tingling ( ) Dull

Location: ( ) Rt side ( ) Lf side ( ) Both Duration: ( ) Constant ( ) Off/on

****

KNEES:

MILD MODERATE SEVERE 1 2 3 4 5 6 7 8 9 10 (10= SEVERE)

( ) Stiff/tight ( ) Ache/sore ( ) Sharp ( ) Burn ( ) Throb ( ) Tingling ( ) Dull

Location: ( ) Rt knee ( ) Lt knee Duration: ( ) Constant ( ) Off/on

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JAW: ( ) Tight/stiff ( ) Ache/sore ( ) Sharp ( ) Popping/clicking ( ) Rt ( ) Lt ( ) Both

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First Name _____Last Name _____Date of birth_____

AUTHORIZATION FOR MEDICAL INFORMATION

This authorization of 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-rays and physical findings, diagnosis and prognosis. You are authorized to provider information in accordance with the Florida "No Fault" Auto Insurance Law.

_____ _____

Patient/Guardian Signature **Date**

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First Name _____Last Name _____Date of birth_____

ASSIGNMENT, LIEN AND AUTHORIZATION OF INSURANCE BENEFITS

I hereby authorize and direct you, my insurance company and/or my attorney, to pay directly to Pronto Urgent Care (Maria Game, MD) such sums as may be due to owing Assignee of services rendered to me, both by reason of accident or illness, and by reason of any other bills that are due Assignee, and to withhold such sums from any disability benefit, medical payment benefits, No-Fault benefits, or any other insurance benefit obligated to reimburse me or form any settlement, judgment or verdict on my behalf as may be necessary to adequately protect said Assignee. I hereby further give a lien to said assignees against any and all insurance benefits named herein and any and all proceeds of any settlement, judgement, or verdict which may be paid to me as a result of the injuries or illness for which I have been treated by Assignee. This s to at as an assignment of my rights and benefits to the extent of the Assignee's services provided. Further, I, hereby instruct the insurance carrier to request that, in the event the subject medical services and/or benefits are disputed for any reason, the amount of the benefits being claimed by Maria Game, MD (Pronto Urgent Care) are to be held in escrow and not disbursed until the dispute is resolved.

In the event the insurance company obligated to make payments to me upon the charges made by the Assignee for their services refused to make such payments, upon demand by me or Assignee, I hereby assign and transfer to Assignee any and all caused of action that I might have or that might exist in my favor against such company and authorize Assignee to prosecute said cause of action either in my name or in Assignee name and further I authorize Assignee to compromise, settle or otherwise resolve said claim or cause of action as they see fit.

I authorize Assignee to release any information pertinent to my case to any insurance company, adjuster or attorney to facilitate collection under this assignment, Lien, and Authorization. I agree that the above mentioned Assignee be given Special Power of Attorney to endorse/sign my name on and all checks and claims forms for payment of my bill.

If I am cash, Medicare or Medicaid patient I understand that the above statement is not applicable and agree that all services rendered to me are charged directly to me and I am personally responsible for payment.

_____ _____

Patient /Guardian Signature **Date**

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