Daugherty Spine & Disk

648 N. Alameda
Las Cruces, NM 88005
d_chiro@hotmail.com
P- 575-521-0022 F-575-521-0033

CONFIDENTIAL HEALTH HISTORY

Name:_____Date of birth:_____Sex: Male/Female
Mailing Address:_____City:_____State:___Zip:____
Home phone:_____Work Phone:_____Cell Phone:_____
Drivers license #:_____State:____Expiration date:_____Married/Single
Social security #:_____Employer:_____
In case of emergency, please notify:_____Phone #:_____

Accident date:_____Time:_____Location:_____
Were you taken to the hospital? Yes/No By ambulance? Yes/No
Name and location of hospital, if applicable:_____
What treatment was rendered at the hospital:_____
_____
Please describe, to the best of your knowledge, what injuries you received in this accident:_____
_____
_____

Where were you seated in the vehicle: Passenger/Driver/Front/Back
Were you aware of the approaching collision prior to impact? Yes/No
Did you lose consciousness (black out) upon impact? Yes/No
Were you wearing a seatbelt? Yes/No If yes: Lap/Shoulder-Lap seatbelt
Road conditions at the time of impact? Wet/Dry/Ice/Other
What type of vehicle were you in? (Make/Model)_____
Estimated speed of the other vehicle(s) at time of impact_____
Describe other vehicle(s) involved (Make/Model)_____
Please describe, to the best of your knowledge what happened during this accident:_____
_____
_____

On what part of the automobile did the following body part hit?

Head_____	Chest_____
Right/Left shoulder_____	Right/Left arm_____
Right/Left hip_____	Right/Left leg_____
Right/Left knee_____	Other_____

If you have been in previous accidents, please list the year of each:_____

Please check off any symptoms you are having:

___Low back problems
___Pain between shoulders
___Neck problems
___Arm problems
___Leg problems
___Swollen joints
___Painful joints
___Stiff joints
___sore muscles
___Weak muscles
___Walking problems
___Ruptures
___Numbness
___Loss of feeling
___Paralysis
___Dizziness
___Fainting
___Headaches
___Muscle jerking
___Convulsions
___Forgetfulness
___Confusion
___Depression
___Broken bones

Are you pregnant? Yes/No
Could you be pregnant? Yes/No
Genito-urinary problems:_____Female problems:_____
Gastro-intestinal problems:_____Eye/Ear/Nose/Throat:_____
Cardio-vascular/respitory:_____
Comments:_____
_____
_____
_____

INSURANCE INFORMATION:
This MUST be filled out completely!

Insurance carrier:_____Agent:_____Phone:_____
Address:_____
Policy/Claim #:_____
Is there a "managed care" provision on this policy? Yes/No/Don't know

Financial Policy:

Insurance policies are contracts between you and your insurance company. The doctor can in no way alter the contract nor guarantee your payments by the insurance company. We will fill out necessary forms for your insurance company. Regardless of this service, however, the patient or guardian is ultimately responsible for payment of all fees.

I understand and agree that all fees for professional services rendered on my behalf are my personal responsibility.

Signed:_____Dated:_____

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NOTICE OF DOCTOR'S LIEN

I do hereby authorize Chris W. Daugherty, DC to furnish you, my attorney and/or insurance company, with a full report of his examination, diagnosis, treatment, prognosis, etc., of myself in regard to the accident in which I was recently involved.

I hereby authorize and direct you, my attorney or insurance company, to pay directly to said doctor such sums as may be due and owing him for medical service 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 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 my settlement, judgment or verdict which may be paid to you, my attorney or insurance company, or myself, as the result of the injuries for which I have been treated or injuries in connection to the accident.

I agree never to rescind this document and that a rescission will not be honored by my attorney. I hereby instruct that in the event another attorney is substituted in this matter, the new attorney will honor this lien as inherent to the settlement and enforceable upon the case as if it were executed by him.

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

I have been advised that if my attorney does not wish to cooperate in protecting the doctor's interest, the doctor will not await payment but may declare the entire balance due and payable by me, the patient.

Dated: _____ _____

Patient's Signature

The undersigned, being attorney 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, or verdict, as may be necessary to adequately protect said doctor above named. Attorney further agrees that in the event this lien is litigated that the prevailing party will be awarded attorney fees and costs.

Dated: _____ _____

Attorney's Signature

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ASSIGNMENT OF BENEFITS

I authorize, Dr. Chris W. Daugherty to release to _____
_____ any medical information necessary to process this claim.
I also request payment of benefits be made directly to Dr. Chris W. Daugherty.

Signed: _____

Printed Name:_____

Date: _____

Claim#: _____

Policy#: _____

NOTE: If the company's policy is to send payment directly to the patient, we request that the check be made payable to both Dr. Chris W. Daugherty and the patient.

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<Authorization to Release Records >

I hereby request and authorize you, your employees and agents to furnish to the person(s) listed below or anyone designated in writing by him/her/them, all records and reports, including x-rays and photostatic copies, abstracts or excerpts of all records and any other information he/she/they may request relating to any examination, treatment or opinion concerning any condition that I may have had in the past or now have.

Please forward the reports and information requested to:

Dr. Chris Daugherty
648 N. Alameda Blvd.
Las Cruces, NM 88005
Office (575) 521-0022
Fax (575) 521-0033

_____ _____

Signature
(Patient or Legal Representative)

(Witness)

_____
Printed Name

_____
Address

_____
City, State, Zip

Date: _____