# PERRONE WELLNESS CENTER, LLC

Referred By ______________________

6 SPRING VALLEY AVE
HACKENSACK, NJ 07601

**GENERAL INFORMATION**

Name: ____________________________________________________Date: ____________

Address: ____________________________City __________________State _____Zip __________

Home Phone: __________________Cell Phone: ________________Other Number: ________________

Email:____________________________________________________________________

Date of Birth: __________________SSN: ______________________________________

Married □ Single □ Divorced □ Widowed □ Student: YES NO

Height: ________________Weight:___________

Insurance Company: ______________________ Insured: __________________________________

If not the insured what is the relationship ______________________________________

**Is your health insurance listed as the primary payer on your automobile insurance policy?** □ Yes □ No

Auto insurance: ______________________________ Claim number: ___________________________

Attorney name: _________________________________ Tel number: ___________________________

Attorney address: ___________________________________________________________

**ACCIDENT DETAILS**

1. Place of Accident (street, city and state): _______________________________________

2. Please explain in detail how your accident happened: __________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________

3. Date of accident: ____/____/____

4. Time of accident _____________A.M. P.M.

5. Your vehicle type:
   □ car □ station wagon □ van □ pickup truck □ large truck □ bus □ other

6. Your position in the vehicle:
   □ Driver □ front passenger □ left rear passenger □ right rear passenger □ other

7. What was your vehicle doing at the time of the accident?
   □ stopped at an intersection □ stopped in traffic □ stopped at a light □ making a right turn
   □ making a left turn □ parking □ proceeding along □ slowing down
   □ accelerating □ other__________________________

8. Visibility at the time of accident? □ Poor □ Fair □ Good

9. Who hit who/what?
   □ you hit other vehicle □ other vehicle hit you □ you hit... (Object) _____________________

10. Road conditions at the time of accident:
   □ Icy □ Wet □ Sandy □ Dark □ Clean and dry

11. Point of impact:
   □ Head-on: □ Left front □ Right front □ Rear-end □ Left rear □ Right rear

12. Did you have your seat belt on? □ Yes □ No

15. Did police show up at the scene? □ Yes □ No

16. Was an accident report filled out? □ Yes □ No

17. Does your vehicle have headrests? □ Yes □ No

18. What was the position of your headrest at the time of the impact?
   □ Even with top of head □ Even with bottom of head □ Middle of neck

19. What was the direction of your head at the time of the impact?
   □ Facing straight forward □ Turned to the right □ Turned to the left

20. Did airbags deploy?
   □ Yes □ No *If YES which side?* □ Driver □ Passenger □ Side

21. Did your body strike the inside of your vehicle? □ Yes □ No
   *If YES describe*: ____________________

22. Did you loose consciousness during the injury?
   □ Yes □ No *If YES for how long?* _______________

23. Your vehicles estimated damage? $______________

24. Where did you go after the accident?
   □ Home □ Work □ Hospital ER □ Private Doctor

25. Name of Hospital or Private Doctor ______________________________________________

26. How did you get there? □ Drove self □ Somebody else □ Ambulance □ Police

27. Were X-rays done? □ Yes □ No

28. Body parts X-rayed? ________________________________________________________

29. Was lab work done? □ Yes □ No

30. Treatments: □ Cervical Collar □ Ice Other: ________________________

**SYMPTOMS**

30. Check symptoms you have noticed since the accident:

□ Headache
□ Neck pain
□ Neck Stiffness
□ Fainting
□ Ringing in ears
□ Loss of smell
□ Pain behind eyes
□ Loss of Memory
□ Dizziness
□ Nausea
□ Confusion
□ Fatigue
□ Tension
□ Irritability
□ Shortness of breath
□ Cold sweats
□ Mid back pain
□ Low back pain
□ Nervousness
□ Loss of taste
□ Toe numbness
□ Constipation
□ Sleeping problems
□ Depression
□ Cold hands
□ Cold feet
□ Diarrhea
□ Anxious
□ Chest pain
□Pins and needles in legs
□ Fever
□ Loss of balance

31. Symptoms other than above: ___________________________________________________

_____________________________________________________________________________

32. At the time of the accident were you working?(WORKERS COMP PURPOSES) □ Yes □ No

33. How many days have you missed from work since your injury?_________________________

Date you returned to work _________/_________/___________________________

*I understand and agree that health accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this Office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.*

Patient's signature: ____________________________________________________________

Guardian or Spouse's Signature: __________________________________Date: ___________