Patient Name: ______________________________ Date of Birth: ____________

Ultima Sports and Spine
219 Lafayette Avenue
Hawthorne, NJ 07506
Phone: 973.423.9100

PERSONAL INJURY INFORMATION SECTION:

ATTORNEY INFORMATION:

Name: ___________________________________ Office Phone Number: ____________________

Address: ____

City: ____ State: ________ Zip: _____________

Date of the accident: ________________ Time of day accident occurred: ___________________

Was a police report filed for the accident? Yes No
Were you in a rental car? Yes No
Were you driving, ON THE CLOCK for Uber or Lyft? Yes No
Were you driving someone else's car? Yes No

Is this your first motor vehicle accident? Yes No
If you answered "No" to the above question, please list all motor vehicle accidents by date and specify what areas of your body were injured and where you treated for your injuries:

____
____
____
____

List all members of your household with their relationship to you:

____
____
____
____

Have you lost time from work? Yes No Dates missed: ______________________________
Are you being compensated? ____
Have you declared bankruptcy since your accident/injuries: Yes No Date:____________

When was your last WORKMAN'S COMP LAWSUIT CASE? _________________________________
When was your last AUTO ACCIDENT LAWSUIT CASE? ___________________________________
When was your last INJURY RELATED LAWSUIT CASE? __________________________________
Explain any of the cases above:

____
____
____

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AUTO INSURANCE INFORMATION:

Do you have a car registered in your name? (circle) Yes No
If you answered "No" above, whom in your household owns a car?
____

Automobile Insurance Company: ______________________________

Policy# ______________________________

Name of Policy Holder (if other than yourself): ______________________________

Address of Policy Holder: ______________________________

City: ______________________ State: _________ Zip: ___________

Your relationship to the policy holder: ______________________________

What is the claim number for your case? ______________________________

The name of the insurance adjuster: ______________________________

How many cars, running, road worthy, or not, do you own in your name? _______
Do you have insurance on all motor vehicles in your name? (circle) Yes No
Did you call in the accident to your insurance company? (circle) Yes No

NATURE OF THE ACCIDENT:

Were you the?	❑Driver	❑Passenger	❑ Pedestrian		
Where were you sitting in the car?	❑Front Seat	❑Back Seat			
Where was the car hit?	❑Front	❑Rear	❑Roof	❑Driver Side	❑Passenger Side
Were you knocked unconscious?	❑Yes	❑No	For How Long? ___________		
Were the police notified?	❑Yes	❑No			
Are you listed on the police report?	❑Yes	❑No			
Were you wearing a seat belt?	❑Yes	❑No			
Did the airbag(s) deploy?	❑Yes	❑No			
Was the car totaled?	❑Yes	❑No	❑Unknown at this time.		
Did you see the accident coming?	❑Yes	❑No			

Did your head or any other body part hit anything during the impact? ❑Yes ❑No
Explain: ______________________________

What direction was your head facing during impact? ❑Forward ❑Left ❑Right ❑Up ❑Down

Total number of people in the car with and including you during the accident: _________

Name of street, city and state the accident occurred in: ______________________________
____

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Did you go to the Emergency Room? ❑Yes ❑No ❑Same Day ❑Next Day ❑Days Later
If "Yes" did you go by ❑Ambulance ❑Drove Yourself ❑Friend/Family

Name of Hospital: ____________________
Were X-rays or CT scans taken of your body? ❑Yes ❑No
If "Yes" What parts? ____________________

What treatment(s) did you receive in the emergency room? Check all that apply:
❑Oral Medication ❑Injections ❑Wound Cleaning ❑Bandaging ❑Anxiety Medication
❑Sutures ❑Splint ❑EKG Test ❑Brace ❑Casting
❑Neck Collar ❑Surgery ❑Ultrasound

What instruction(s) did you receive at discharge from the emergency room? Check all that apply:
❑No further care necessary ❑See Physical Therapist ❑See Pain Management ❑Take muscle relaxer
❑See Chiropractor ❑See Neurologist ❑No work ❑Rest
❑See Primary Care Doctor ❑See Orthopedist ❑Take pain medication ❑Ice

What other doctors have you seen since the accident? ____________________

DESCRIBE THE ACCIDENT:

____

____

____

____

CHECK ALL THE SYMPTOMS YOU NOTICED IMMEDIATELY AFTER THE ACCIDENT:
❑Headaches ❑Pins & Needles in your arms ❑Dizziness ❑Jaw Pain
❑Neck Pain ❑Pins & Needles in your legs ❑Chest Pain ❑Jaw clicking
❑Neck Stiffness ❑Numbness/Tingling in Fingers ❑Shoulder Pain ❑Loss of Sleep
❑Mid Back Pain ❑Numbness/Tingling in Toes ❑Hip Pain ❑Ankle Pain
❑Low Back Pain ❑Wrist Pain ❑Knee Pain ❑Elbow Pain
❑Anxiety ❑Nervousness ❑Trembling ❑Difficulty Breathing
❑Other: ____________________

Did you break any bones? ❑Yes ❑No
Explain: ____________________

Is there any bruising on your body? ❑Yes ❑No ❑Pictures Taken
Explain: ____________________

Do you have any open wounds from the accident? ❑Yes ❑No ❑Pictures Taken
Explain: ____________________

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OFFICE POLICY REGARDING PERSONAL INJURY PROTECTION (PIP) ASSIGNMENT

Our office is pleased to accept your automobile insurance assignment as soon as your EXACT COVERAGE is verified by the front desk office staff or responsible party. We will file your claim forms and assist you in any way that we can. However, it must be fully understood, and PLEASE NOTE that your automobile insurance is a CONTRACT that was made between YOU and YOUR CAR INSURANCE COMPANY. Please contact your automobile insurance company with any questions or concerns regarding your benefits/coverage. By law, regardless of where you receive treatment for your injuries, YOU are ultimately responsible to pay any outstanding deductible(s), co-payments or co-insurance fees required at the time services are rendered. Please keep reading.

The privilege of using your automobile insurance to pay for your medical bills begins when this office receives your completed insurance forms and your insurance is "QUALIFIED" for coverage. Your car insurance policy must be active and in good standing at the time of your accident. You are considered a cash paying patient until this office receives permission and qualifies your coverage from the insurance company to determine the extent of the benefits under your policy. Please keep reading.

I have been made aware of the New Jersey No Fault Insurance Act and realize that I am responsible for payment of a deductible of $250 or more, whichever I elected to choose when I purchased my car insurance. A co-payment of 20% of the approved treatment fees with a maximum per visit fee of $105.00 is my responsibility. I am aware that this fee does not pertain to x-rays, examinations or testing, which are regulated by separate fee maximums as per the NJ PIP fee schedule. In consideration of the courtesy afforded to me by this office, I acknowledge that if I retain an attorney to protect my case, the deductible and co-payments or co-insurance fees as well as any fees associated with making copies of my medical record and preparation of any narrative reports or court testimony fees will be paid from the proceeds of any settlement obtained due to the legal action at the time funds are dispersed. In the event that there is no legal action or the legal action is not successful, I hereby agree to personally pay for all the above fees not to exceed the maximum provided for the NJ PIP statutes and regulations. Payment plans will be available if this situation arises.

I hereby request my automobile insurance company, ____, to make DIRECT PAYMENTS, as stated on enclosed bills, to Dr. Peter J. Berger at Ultima Sports and Spine, located at 219 Lafayette Avenue, Hawthorne, NJ 07506. This statement applies to insurance assignment and/or an attorney lien against any settlement made in conjunction with the above named patient for condition or injuries for which I am being treated for in the office of the above named chiropractic physician.

By signing below, you acknowledge, accept and agree to all the terms and conditions of this notice.

______________________________	______________________________	_____________
Patient's Name (Print)	Patient's Signature/Parent or Guardian	Date
______________________________	______________________________	
Witness Name (Print)	Witness Signature	