# ACCIDENT & INJURY CENTER, INC.
# P.O. BOX 790012
# Charlotte, NC 28206-0012

PATIENT REGISTRATION FORM

**Ph. #** *(telefono)* _____ **Acct. #** _____
**Last:** *(apellido)* _____ **First** *(Nombre)*: _____ **MI:** _____
**Social Sec. #***(# del Seguro Social)* _____ **DOB:** *(Fecha de Nacimiento)* _____
**Age** *(Edad)* _____ **Sex** *(Sexo)* _____ **Marital Status** *(estado civil)* _____
**Address** *(Direccion)*

_____

**City** *(Ciudad)* _____ **Zip** *(Codigo Postal)* _____
**Driver lic. #** *(# de licencia)* _____
**Referred by** *(Referido por)* _____

**Personal Injury** *(Accidente)* **Yes** *(Si)* **No** **Date of Injury** *(Dia del Accidente)* _____
**Attorney Name & Address** *(Nombre y Direccion de Abogado)*

_____

**Responsible Party** *(Persona Responsable)* _____
**Relationship to Patient** *(Relacion)* _____
**Soc. Sec. #** *(Numero del Seguro Social)* _____ **Phone** *(Telefono)* _____

**Employer** *(Trabajo)* _____ **Work Ph#** *(Tel. Del Trabajo)* _____
**Occupation** *(Ocupacion)* _____
**Nearest Relative** *(familiar mas cercano)* _____
**Pts Relationship** *(Relacion)* _____ **Phone** *(Tel #)* _____

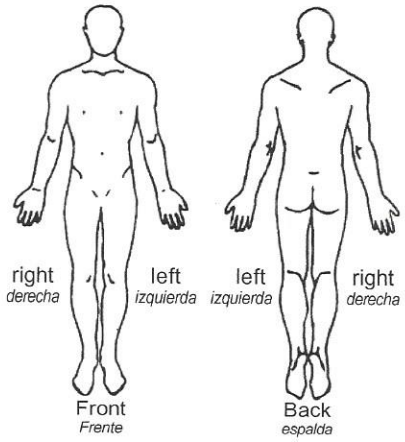
**Primary Ins. Company** ***(Seguro primario)***
**(liability)** _____ **Phone** *(Telefono)* _____
**Complete Addrs:** *(direccion)* _____

**Health Insurance: Carrier** *(Seguro Medico)* _____ **Phone** *(Tel.)* _____
**Address** *(Direccion)* _____
**City** *(Ciudad)* _____ **Zip** *(Codigo Postal)* _____
**Phone** *(Tel.)* _____
**MED PAY INSURANCE CO.**
**Carrier** *(Seguro Medico)* _____ **Phone** *(Tel.)* _____
**Address** *(Direccion)* _____
**City** *(Ciudad)* _____ **Zip** *(Codigo Postal)* _____

I, the undersigned, certify that I (or my dependent) have insurance coverage with _____ insurance company and assign directly to _____ all benefits, if any otherwise payable to me for services rendered. I understand that I am financially responsible for deductibles and co-pays. I hereby authorize the Doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible party signature *(Firma)* _____
Print name: *(Nombre)* _____

Relationship *(Relacion)* _____ Date *(Fecha)* _____




| Symptons: (Sintomas) | |
|---|---|
| | |
| | |
| | |
| | |

**Did you have an accident?** *(usted tuvo un accidente?)* ☐ **Yes** *(Si)* ☐ **No If yes, where?** *(Donde fue)*

☐ **At Home** *(casa)* ☐ **Automobile** *(Carro)* ☐ **On Job** *(Trabajo)* ☐ **Other** *(otro lugar)*

**Date of Accident?** *(Dia del accidente)* _____ **Time** *(Hora)* _____ **Place***(Lugar)* _____

**Has the condition been getting better, worse, or staying the same?** _____

*Esta condicion ha mejorado, empeorado, o lo mismo?* _____

**Anything makes this condition worse?** *(algo que agrave su condicion?)* _____

**Have you ever had surgery?** *(Ha tenido cirugias antes)* ☐ **Yes** *(Si)* ☐ **No If yes, what for and when?**

*(si puso que si cuando)* _____

**DRUGS YOU TAKE KNOW** *(MEDICINA QUE USTED TOMA)* ☐ **Pain Killers** *(dolor)*

☐ **Muscle relaxers** *(muscular)* ☐ **Nerve Pills** *(para los nervios)* ☐ **Others** *(otras)*

**CHECK SYMPTOMS YOU HAVE SINCE THE ACCIDENT**
**(POR FAVOR ESCRIBA LOS SINTOMAS QUE TIENE DESDE EL ACCIDENTE)**

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| | | | | |
|---|---|---|---|---|
| ☐ **Headache** *(dolor de cabeza)* | ☐ **Neck Pain** *(dolor de cuello)* | ☐ **Neck Stiff** *(cuello rigido)* | ☐ **Sleeping prob-lems** *(problemas para dormir)* | ☐ **Back pain** *(dolor de espalda)* |
| ☐ **Tension** | ☐ **Nervousness** *(nerviosismo)* | ☐ **Chest Pain** *(dolor de pecho)* | ☐ **Pin and needles in arms** *(sensacion de agujas en los brazos)* | ☐ **Pin and needles in the legs** *(sensacion de agujas en las piernas)* |
| ☐ **Fatigue** *(fatiga)* | ☐ **Ears ring** *(timbre en los oidos)* | ☐ **Depression** | ☐ **Eye problems** *(problemas en los ojos)* | ☐ **Numbness** *(falta de sensacion)* |

**Symptoms other than above?** *(otros sintomas)* _____

**Lost days from work?** *(dias perdidos en el trabajo)* **Yes** *(si)* **No Dates** *(dias)* _____

Fees are payable at the time x-rays, examinations and treatments are received, unless other arrangements are made. *(todo el pago es requerido en el dia que todos los servicios son dados)*
*X-rays remain the property of this clinic. (rayos x son propiedad de la clinics)*

**Patient signature: (Firma)** _____ **Date (dia)** _____