PATIENT HISTORY QUESTIONNAIRE
(HISTORIAL DEL PACIENTE)

Patient Name / (Nombre): _____
(Last Name) (First Name)

Address/ (Direccion): _____

City: _____ **State:** _____ **Zip:** _____

Phone # (Telefono) (Home) _____ **(Work)** _____

Sex: (Sexo) M / F **Date of Birth: (Fecha de Nacimiento)** _____ **S.S. # (Seguro Social)** _____
(mm/dd/yy)

Nature of Accident: (Accidence) ☐ Automobile (Auto) ☐ Slip & Fall (Caida) ☐ Work Related (Trabajo) Other: _____ (Otros)

Date of Accident: (Fecha de Accidente) _____

Insurance Name: _____ **Phone#** _____

Address (Direccion): _____

Claim # (Numero de Reclamo): _____ **Policy # (Numero de Poliza):** _____

Attorney's Name: _____ **Attorney's Phone#** _____
(Nombre de Abogado) (Telefono de Abogado)

Attorney's address / (Direccion): _____

Health Insurance (Plan Medico): _____ **Phone#** _____

Address: _____

Subscriber ID # _____ **Group #** _____

BENEFITS

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THIS OFFICE FOR PROFESSIONAL SERVICE RENDERED, AND I SHALL BE PERSONALLY RESPONSIBLE FOR ANY UNPAID BALANCE TO THE DOCTOR, I HEREBY AUTHORIZE THE ATTENDING DOCTOR TO RELEASE ANY INFORMATION CONCERNING MY EXAMINATION OR TREATMENT THAT MAY BE NECESSARY OF EITHER MEDICAL CARE, LEGAL DOCUMENTATION OR PROCESSING APPLICATION FOR FINANCIAL BENEFITS.

BENEFICIOS

YO AUTORIZO PAGO DIRECTO A ESTA OFICINA POR SERVICIOS PROFECIONALS RECIVIDOS, SOY PERSONALMENTE RESPONSIBLE POR SERVICIOS MEDICOS NO PAGADOS, AUTORIZO A EL DOCTOR A REVELAR CUALQUIE INFORMATION QUE CONSIERNA MI CONSULTA O TRATAMIENTO RESIVIDOS YA SEA A MI SEGURO, ABOGADO, OTROS MEDICOS.

Patient Signature: _____ **Guardian:** _____ **Date:** _____
(Firma del Paciente) (Tutor) (Dia)

ASSIGNMENT OF BENEFITS & LIMITED POWER OF ATTORNEY

Patient's Name:_____

Date of Injury:_____

I irrevocably assign to _____, all of my rights and benefits under my insurance contract for payment for services rendered to me. I authorize you to file insurance claims on my behalf for services rendered to me as a result of this accident and this specifically includes filing arbitration/litigation in your name on my behalf against the PIP carrier/Healthcare carrier. I irrevocably authorize you to retain an attorney of your choice on my behalf for collection of your bills. I direct that all reimbursable medical payments go directly to you, my medical provider. I authorize you to act on my behalf. I consent to your acting on my behalf in this regard and in regard to my general health insurance coverage pursuant to the "benefit denial appeals process" set forth in the NJ Administrative code.

In the event the insurance carrier responsible for making medical payments in this matter does not accept my assignment, or my assignment is deemed invalid, I execute this limited power of attorney and appoint your collection attorney as my agent to collect payment for your medical services directly against the carrier in this case including filing an arbitration demand or lawsuit. I specifically authorize that attorney to file directly against that carrier in my name or in your name as a medical provider rendering services to me.

I authorize you and or your assigned to obtain medical information regarding my physical condition from any other health care provider, including hospitals, diagnostic centers, etc., and I specifically authorize such health care provider to release all such information to you about me, including medical reports, X-ray reports, narrative reports, and any other report or information regarding my physical condition.

DATED: _____ PATIENT' S SIGNATURE: _____