LOUISIANA
HEALTH & INJURY CENTERS

CONFIDENTIAL PATIENT INFORMATION

Date ________________________

NAME: ______________________________ ADDRESS: ____

CITY: ______________ STATE: _____ ZIP: ________________ HOME PHONE: __________________________

CELL PHONE: _____________ SEX: _____ MARITAL STATUS:_____ D.O.B.: _______________ AGE: _______

S.S. #: _______________________ # OF CHILDREN: __________ D.L. #: ______________________________

EMPLOYER: _______________________________ OCCUPATION: _______________________________________

NAME OF SPOUSE: ___________________________________ CELL PHONE: ______________________________

NAME OF NEAREST RELATIVE: ____________________________________ HOME PHONE: ____________________
(NOT LIVING WITH YOU)

TYPE OF ACCIDENT: ❏ NONE ❏ WORK RELATED ❏ AUTO ACCIDENT ❏ SLIP AND FALL ❏ OTHER

DATE OF ACCIDENT: ____________________________

BRIEFLY DESCRIBE SYMPTOMS: ____

____

LIST OTHER DOCTORS SEEN FOR THIS CONDITION: ____

MEDICAL HISTORY

❏ AIDS
❏ HIV
❏ ANEMIA
❏ ASTHMA
❏ CANCER
❏ CONVULSIONS
❏ DIABETES
❏ DIGESTIVE DISORDER
❏ EPILEPSY
❏ HEART TROUBLE
❏ REPRODUCTIVE DISORDERS
❏ HIGH BLOOD PRESSURE
❏ KIDNEY DISORDER
❏ MULTIPLE SCLEROSIS
❏ MUSCULAR DYSTROPHY
❏ POLIO
❏ HEPATITIS
❏ RHEUMATIC FEVER
❏ RHEUMATISM
❏ SCARLET FEVER
❏ TUBERCULOSIS
❏ VENEREAL DISEASE
❏ GERMAN MEASLES

ARE YOU PREGNANT? ❏ YES ❏ NO IF SO, WHAT IS YOUR DUE DATE?__________________________

ARE YOU ALLERGIC TO ANY MEDICATIONS? ❏ YES ❏ NO IF SO, WHAT KINDS?______________________

ARE YOU CURRENTLY TAKING ANY MEDICATIONS? ____

HAVE YOU BEEN TREATED BY A PHYSICIAN FOR ANY HEALTH CONDITION IN THE PAST YEAR? ❏ YES ❏ NO

DESCRIBE CONDITION:____

DO YOU HAVE HEALTH INSURANCE? ❏ YES ❏ NO

NAME OF INS CO: ______________________________ PHONE: _____________________________________

NAME OF POLICY HOLDER: _________________________ POLICY HOLDER'S S.S. #: ___________________

MEMBER #:____________________________________ GROUP #: ____________________________________

PATIENT SIGNATURE: ____ DATE:________________________

LOUISIANA
HEALTH & INJURY CENTERS

ACCIDENT INFORMATION

DATE OF ACCIDENT: ______________________ TIME OF ACCIDENT: ______________ ❏ AM ❏ PM

WORK RELATED ACCIDENT VICTIMS ONLY:

EMPLOYER: ____________________ TYPE OF BUSINESS: ______________ PHONE: __________________

HAS ACCIDENT BEEN REPORTED TO SUPERVISOR/EMPLOYER? ❏ YES ❏ NO

HAS A WORKER'S COMPENSATION CLAIM BEEN FILED? ❏ YES ❏ NO

TRAFFIC ACCIDENT VICTIMS ONLY:

WERE YOU THE: ❏ DRIVER ❏ PASSENGER ❏ PEDESTRIAN

IF PASSENGER, PLEASE INDICATE YOUR LOCATION IN THE VEHICLE: ____________________________

YEAR/MAKE/MODEL OF VEHICLE YOU WERE IN: ____

YEAR/MAKE/MODEL OF OTHER VEHICLE INVOLVED IN THIS ACCIDENT: ____________________________

WAS ACCIDENT REPORTED TO POLICE DEPARTMENT? ❏ YES ❏ NO

WERE ANY CITATIONS ISSUED? ❏ YES ❏ NO TO WHOM? ______________________________

ACCIDENT DESCRIPTION:

EXPLAIN HOW THE ACCIDENT HAPPENED: ____

____

DID YOU GO TO THE HOSPITAL OR ANOTHER DOCTOR AFTER THE ACCIDENT? ❏ YES ❏ NO
WHERE DID YOU GO? ____
WHEN DID YOU GO? ____
HOW DID YOU GET THERE? ❏ PRIVATE TRANSPORTATION ❏ AMBULANCE

PLEASE CHECK THE FOLLOWING ACTIVITIES THAT AGGRAVATE YOUR CONDITION:

❏ BENDING ❏ TURNING HEAD ❏ SNEEZING ❏ LIFTING
❏ STANDING ❏ REACHING ❏ SITTING ❏ WALKING
❏ STRAINING AT STOOL ❏ LYING DOWN ❏ COUGHING

PLEASE CHECK THE FOLLOWING SYMPTOMS YOU MAY BE EXPERIENCING:

❏ BLURRED VISION
❏ BUZZING IN EARS
❏ MUSCLE JERKING
❏ FAINTING
❏ DIARRHEA
❏ DIZZINESS
❏ HEADACHES
❏ FATIGUE
❏ DEPRESSION
❏ INSOMNIA
❏ NUMBNESS IN FINGERS
❏ PINS AND NEEDLES IN ARMS
❏ SHORTNESS IN BREATH
❏ STIFF NECK
❏ STOMACH UPSET
❏ NUMBNESS IN TOES
❏ PINS AND NEEDLES IN LEGS
❏ HEAD SEEMS TOO HEAVY
❏ CONSTIPATION
❏ LOSS OF BALANCE

SYMPTOMS OTHER THAN ABOVE: ____

PATIENT SIGNATURE: _________________________________ DATE: ____________________

LOUISIANA
HEALTH & INJURY CENTERS

AUTOMOBILE ACCIDENT QUESTIONNAIRE

DATE ______________________________

PATIENT'S NAME ______________________________

DATE OF ACCIDENT ______________________________

THE FOLLOWING QUESTIONS PERTAIN TO YOU AND THE VEHICLE YOU WERE IN:

VEHICLE TYPE:
❏ CAR ❏ PICKUP
❏ VAN ❏ TRUCK
❏ STATION WAGON ❏ BUS
❏ OTHER____________________

VEHICLE SIZE:
❏ SUBCOMPACT ❏ FULL-SIZE
❏ COMPACT ❏ MINI
❏ MID-SIZE ❏ LIGHT
❏ HEAVY ❏ OTHER____________________

YOUR POSITION IN THE VEHICLE:
❏ DRIVER
❏ PASSENGER --------------- LOCATION: ❏ LEFT ❏ MIDDLE ❏ RIGHT
❏ OTHER____________________ ❏ FRONT PASSENGER ❏ REAR PASSENGER ❏ THIRD SEAT (REAR)

SPEED OF YOUR VEHICLE:
❏ STOPPED ❏ MOVING MODERATELY
❏ PARKED ❏ MOVING FAST
❏ SLOWING ❏ MOVING AT APPROX. ______MPH
❏ MOVING SLOWLY

WHY VEHICLE WAS SLOWED OR STOPPED:
❏ TRAFFIC SIGNAL ❏ PARKING
❏ PEDESTRIAN ❏ TRAFFIC
❏ STOP SIGN ❏ BUSY INTERSECTION

COLLISION TYPE:
❏ DRIVER SIDE IMPACT ❏ HEAD ON COLLISION
❏ PASSENGER SIDE IMPACT ❏ REAR IMPACT
❏ FRONT IMPACT ❏ PEDESTRIAN INCIDENT

THE FOLLOWING QUESTIONS PERTAIN TO THE OTHER VEHICLE INVOLVED IN THE ACCIDENT:

VEHICLE TYPE:
❏ CAR ❏ PICKUP
❏ VAN ❏ TRUCK
❏ STATION WAGON ❏ BUS
❏ OTHER____________________

VEHICLE SIZE:
❏ SUBCOMPACT ❏ FULL-SIZE
❏ COMPACT ❏ MINI
❏ MID-SIZE ❏ LIGHT
❏ HEAVY ❏ OTHER____________________

CONDITIONS AT THE TIME OF ACCIDENT:

TIME OF DAY:
❏ FULL DAYLIGHT
❏ DAWN
❏ DUSK
❏ NIGHT

ROAD CONDITIONS:
❏ DRY
❏ DAMP
❏ WET
❏ SNOW COVERED
❏ ICE COVERED
❏ PATCHY ICE/SNOW

VISIBILITY:
❏ EXCELLENT
❏ GOOD
❏ FAIR
❏ POOR

VISIBILITY COMPROMISED BY:
❏ BRIGHTNESS
❏ DARKNESS
❏ RAIN
❏ SNOW
❏ FOG
❏ TRAFFIC

THE FOLLOWING QUESTIONS CONCERN THE MOMENT OF IMPACT OF THE ACCIDENT:

WERE YOU...
❏ TOTALLY UNAWARE THAT THE ACCIDENT WAS IMPENDING
❏ AWARE THAT THE ACCIDENT WAS IMPENDING
❏ AWARE THAT THE ACCIDENT WAS IMPENDING AND BRACED FOR IT

RESTRAINTS: (CHECK ALL THAT APPLY)
❏ SEAT BELT
❏ SHOULDER HARNESS
❏ NO RESTRAINTS

IF YOU WERE THE DRIVER OF THE VEHICLE, WAS YOUR FOOT ON THE BRAKE PEDAL? ❏ YES ❏ NO ❏ KNOCKED OFF BY IMPACT

WAS THE AIR BAG DEPLOYED?
❏ CAR NOT EQUIPPED WITH AIR BAG
❏ AIR BAG DEPLOYED
❏ AIR BAG NOT DEPLOYED

WHAT POSITION WAS YOUR HEADREST IN?
❏ HIGH POSITION
❏ MIDDLE POSITION
❏ LOW POSITION

LOUISIANA
HEALTH & INJURY CENTERS

POSITION OF YOUR HEAD AT TIME OF IMPACT:
- ❏ FACING STRAIGHT AHEAD
- ❏ TILTED FORWARD
- ❏ ROTATED TO THE LEFT
- ❏ ROTATED TO THE RIGHT

WAS YOUR HEAD THROWN...?
- ❏ BACKWARD AND THEN FORWARD
- ❏ FORWARD AND THEN BACKWARD
- ❏ TO THE LEFT
- ❏ TO THE LEFT THEN THE RIGHT
- ❏ TO THE RIGHT
- ❏ TO THE RIGHT THEN THE LEFT

POSITION OF YOUR BODY AT TIME OF IMPACT:
- ❏ STRAIGHT
- ❏ TILTED FORWARD
- ❏ ROTATED TO THE LEFT
- ❏ ROTATED TO THE RIGHT

WAS YOUR BODY THROWN...?
- ❏ BACKWARD AND THEN FORWARD
- ❏ FORWARD AND THEN BACKWARD
- ❏ TO THE LEFT
- ❏ TO THE LEFT THEN THE RIGHT
- ❏ TO THE RIGHT
- ❏ TO THE RIGHT THEN THE LEFT
- ❏ ACROSS THE VEHICLE
- ❏ OUTSIDE THE VEHICLE
- ❏ UNDER THE VEHICLE

DAMAGE TO THE VEHICLE YOU WERE IN:
- ❏ INCURRED MINIMAL DAMAGE
- ❏ INCURRED MODERATE DAMAGE
- ❏ INCURRED SEVERE DAMAGE
- ❏ WAS TOTALLED
- ❏ NOT KNOWN

CITATIONS:
- ❏ NONE ISSUED
- ❏ YOURSELF
- ❏ DRIVER OF VEHICLE PATIENT WAS A PASSENGER OF
- ❏ DRIVER OF OTHER VEHICLE
- ❏ NOT SURE

AS A RESULT OF THE FORCE OF THE COLLISION, WHICH OBJECTS IN THE VEHICLE DID YOUR BODY STRIKE?

HEAD:
- ❏ STEERING WHEEL
- ❏ DASHBOARD
- ❏ WINDSHIELD
- ❏ ARMREST
- ❏ HEADREST
- ❏ REAR VIEW MIRROR
- ❏ LEFT DOOR
- ❏ RIGHT DOOR
- ❏ LEFT WINDOW
- ❏ RIGHT WINDOW
- ❏ CONSOLE
- ❏ GEAR SHIFT
- ❏ FRONT SEAT
- ❏ BACK SEAT

TORSO:
- ❏ STEERING WHEEL
- ❏ DASHBOARD
- ❏ WINDSHIELD
- ❏ ARMREST
- ❏ HEADREST
- ❏ REAR VIEW MIRROR
- ❏ LEFT DOOR
- ❏ RIGHT DOOR
- ❏ LEFT WINDOW
- ❏ RIGHT WINDOW
- ❏ CONSOLE
- ❏ GEAR SHIFT
- ❏ FRONT SEAT
- ❏ BACK SEAT

LEFT ARM:
- ❏ STEERING WHEEL
- ❏ DASHBOARD
- ❏ WINDSHIELD
- ❏ ARMREST
- ❏ HEADREST
- ❏ REAR VIEW MIRROR
- ❏ LEFT DOOR
- ❏ RIGHT DOOR
- ❏ LEFT WINDOW
- ❏ RIGHT WINDOW
- ❏ CONSOLE
- ❏ GEAR SHIFT
- ❏ FRONT SEAT
- ❏ BACK SEAT

RIGHT ARM:
- ❏ STEERING WHEEL
- ❏ DASHBOARD
- ❏ WINDSHIELD
- ❏ ARMREST
- ❏ HEADREST
- ❏ REAR VIEW MIRROR
- ❏ LEFT DOOR
- ❏ RIGHT DOOR
- ❏ LEFT WINDOW
- ❏ RIGHT WINDOW
- ❏ CONSOLE
- ❏ GEAR SHIFT
- ❏ FRONT SEAT
- ❏ BACK SEAT

LEFT LEG:
- ❏ STEERING WHEEL
- ❏ DASHBOARD
- ❏ WINDSHIELD
- ❏ ARMREST
- ❏ HEADREST
- ❏ REAR VIEW MIRROR
- ❏ LEFT DOOR
- ❏ RIGHT DOOR
- ❏ LEFT WINDOW
- ❏ RIGHT WINDOW
- ❏ CONSOLE
- ❏ GEAR SHIFT
- ❏ FRONT SEAT
- ❏ BACK SEAT

RIGHT LEG:
- ❏ STEERING WHEEL
- ❏ DASHBOARD
- ❏ WINDSHIELD
- ❏ ARMREST
- ❏ HEADREST
- ❏ REAR VIEW MIRROR
- ❏ LEFT DOOR
- ❏ RIGHT DOOR
- ❏ LEFT WINDOW
- ❏ RIGHT WINDOW
- ❏ CONSOLE
- ❏ GEAR SHIFT
- ❏ FRONT SEAT
- ❏ BACK SEAT

THE FOLLOWING QUESTIONS CONCERN THE TIME PERIOD IMMEDIATELY FOLLOWING THE ACCIDENT:

DID YOU LOSE CONSCIOUSNESS?

❑ YES
❑ NO

IMMEDIATELY FOLLOWING THE ACCIDENT, DID YOU FEEL...?

❑ DIZZY ❑ WEAK
❑ DAZED ❑ NERVOUS
❑ DISORIENTED ❑ NAUSEATED

WERE YOU ABLE TO WALK UNAIDED?

❑ YES
❑ NO

WHERE DID YOU GO?

❑ DROVE HOME ❑ DROVE TO WORK
❑ WAS DRIVEN HOME ❑ WAS DRIVEN TO WORK
❑ DROVE TO HOSPITAL ❑ DROVE TO SCHOOL
❑ WAS DRIVEN TO HOSPITAL ❑ WAS DRIVEN TO SCHOOL
❑ TAKEN TO HOSPITAL VIA AMBULANCE

NEXT DAY DISCOMFORT...?

❑ INCREASED ❑ DECREASED ❑ SAME

IN WHAT AREAS DID YOU IMMEDIATELY FEEL PAIN?

❑ HEAD	SHOULDER -	❑ LEFT	❑ RIGHT	HIP -	❑ LEFT	❑ RIGHT
❑ NECK	ARM -	❑ LEFT	❑ RIGHT	THIGH -	❑ LEFT	❑ RIGHT
❑ UPPER BACK	ELBOW -	❑ LEFT	❑ RIGHT	KNEE -	❑ LEFT	❑ RIGHT
❑ MID BACK	WRIST -	❑ LEFT	❑ RIGHT	CALF -	❑ LEFT	❑ RIGHT
❑ RIBS	HAND -	❑ LEFT	❑ RIGHT	ANKLE -	❑ LEFT	❑ RIGHT
❑ CHEST	FINGERS -	❑ LEFT	❑ RIGHT	FOOT -	❑ LEFT	❑ RIGHT
❑ ABDOMEN	BUTTOCK -	❑ LEFT	❑ RIGHT	TOES -	❑ LEFT	❑ RIGHT
❑ LOW BACK	❑ PELVIS					

IN WHAT AREAS DID YOU EXPERIENCE LACERATIONS (CUTS)?

❑ HEAD	SHOULDER -	❑ LEFT	❑ RIGHT	HIP -	❑ LEFT	❑ RIGHT
❑ NECK	ARM -	❑ LEFT	❑ RIGHT	THIGH -	❑ LEFT	❑ RIGHT
❑ UPPER BACK	ELBOW -	❑ LEFT	❑ RIGHT	KNEE -	❑ LEFT	❑ RIGHT
❑ MID BACK	WRIST -	❑ LEFT	❑ RIGHT	CALF -	❑ LEFT	❑ RIGHT
❑ RIBS	HAND -	❑ LEFT	❑ RIGHT	ANKLE -	❑ LEFT	❑ RIGHT
❑ CHEST	FINGERS -	❑ LEFT	❑ RIGHT	FOOT -	❑ LEFT	❑ RIGHT
❑ ABDOMEN	BUTTOCK -	❑ LEFT	❑ RIGHT	TOES -	❑ LEFT	❑ RIGHT
❑ LOW BACK	❑ PELVIS					

AT THE HOSPITAL, WHAT AREAS WERE X-RAYED?

❑ HEAD	SHOULDER -	❑ LEFT	❑ RIGHT	HIP -	❑ LEFT	❑ RIGHT
❑ NECK	ARM -	❑ LEFT	❑ RIGHT	THIGH -	❑ LEFT	❑ RIGHT
❑ UPPER BACK	ELBOW -	❑ LEFT	❑ RIGHT	KNEE -	❑ LEFT	❑ RIGHT
❑ MID BACK	WRIST -	❑ LEFT	❑ RIGHT	CALF -	❑ LEFT	❑ RIGHT
❑ RIBS	HAND -	❑ LEFT	❑ RIGHT	ANKLE -	❑ LEFT	❑ RIGHT
❑ CHEST	FINGERS -	❑ LEFT	❑ RIGHT	FOOT -	❑ LEFT	❑ RIGHT
❑ ABDOMEN	BUTTOCK -	❑ LEFT	❑ RIGHT	TOES -	❑ LEFT	❑ RIGHT
❑ LOW BACK	❑ PELVIS					

WHERE DID YOU EXPERIENCE PAIN ON THE DAY FOLLOWING THE ACCIDENT?

❑ HEAD	SHOULDER -	❑ LEFT	❑ RIGHT	HIP -	❑ LEFT	❑ RIGHT
❑ NECK	ARM -	❑ LEFT	❑ RIGHT	THIGH -	❑ LEFT	❑ RIGHT
❑ UPPER BACK	ELBOW -	❑ LEFT	❑ RIGHT	KNEE -	❑ LEFT	❑ RIGHT
❑ MID BACK	WRIST -	❑ LEFT	❑ RIGHT	CALF -	❑ LEFT	❑ RIGHT
❑ RIBS	HAND -	❑ LEFT	❑ RIGHT	ANKLE -	❑ LEFT	❑ RIGHT
❑ CHEST	FINGERS -	❑ LEFT	❑ RIGHT	FOOT -	❑ LEFT	❑ RIGHT
❑ ABDOMEN	BUTTOCK -	❑ LEFT	❑ RIGHT	TOES -	❑ LEFT	❑ RIGHT
❑ LOW BACK	❑ PELVIS					

PATIENT'S SIGNATURE:____

LOUISIANA
HEALTH & INJURY CENTERS

PATIENT:____

ADDRESS:____

____

ATTORNEY:____

INSURANCE CARRIER: ________________________________

ASSIGNMENT OF PAYMENT

My attorney and/or insurance carrier are hereby authorized and requested to pay directly to **LOUISIANA HEALTH & INJURY CENTERS** any monies due on my account, the same to be deducted from settlement made on my behalf.

Dated at__________am/pm this________day of________________________, 20_.
TIME DATE MONTH

Witness **Patient Signature**

AUTHORIZATION OF RELEASE OF CASE RECORDS

I hereby authorize **LOUISIANA HEALTH & INJURY CENTERS** to disclose my medical records or any information, which he may have acquired by examination or other means of my physical or mental condition; and I hereby release them of any consequences thereof.

Dated at__________am/pm this________day of________________________, 20_.
TIME DATE MONTH

Witness **Patient Signature**

13406 Airline Highway
Baton Rouge, LA 70817

Tel: 225.752.2760
Fax: 225.751.6908

LOUISIANA
HEALTH & INJURY CENTERS

PATIENT NAME: ______________________________

ADDRESS: ______________________________

____

DATE OF ACCIDENT: ______________________________

TIME OF ACCIDENT: ______________________________

Were you the: **DRIVER** **PASSENGER** **PEDESTRIAN**

If you were NOT the driver, who was? ______________________________

Location of accident: ______________________________

____

Was any information exchanged? Any information that you have will be helpful.

Insured: ______________________________
NAME OF OTHER DRIVER

Insurance Company: ______________________________
OTHER VEHICLE

Phone Number: ______________________________

Adjuster: ______________________________

Claim Number: ______________________________

LOUISIANA
HEALTH & INJURY CENTERS

CONSENT TO TREATMENT OF A MINOR CHILD

I,____________________________________hereby consent to **Dr. Michael Goff**
(PRINT NAME OF PARENT/LEGAL GUARDIAN)

and his staff to treat ______________________________________ as he sees fit.
(PRINT NAME OF MINOR CHILD)

____

Signature of Parent/Legal Guardian

LOUISIANA
HEALTH & INJURY CENTERS

AUTHORIZATION FOR RELEASE OF RECORDS

PATIENT: ____

ADDRESS: ____

____

I hereby authorize ____________________________ to disclose to **LOUISIANA HEALTH & INJURY CENTERS** or their agents any information, which he may have acquired by examination or other means of my physical or mental condition; and I hereby, release him of any consequences thereof.

Dated at ____________ this ________ day of ______________________, 20_____.
TIME DATE MONTH

Patient Signature	**Witness**
Date of Birth	**Date of Accident**
Patient Social Security Number	**Fax#**

13406 Airline Highway
Baton Rouge, LA 70817

Tel: 225.752.2760
Fax: 225.751.6908