

NO-FAULT

ENRIQUE ERGAS, M.D., P.C.

NAME: _____ EMPLOYER: _____

ADDRESS: _____

APT # _____ CITY: _____

STATE: _____ ZIP CODE: _____ OCCUPATION: _____

PHONE: _____ (HOME) SS # _____

_____ (WORK) D/A: _____

D/B: _____ AGE: _____ MARITAL STATUS: S M D W SEP

INSURANCE: _____ REFERRAL _____

POLICY # _____ TELEPHONE: _____

FILE # _____

POLICYHOLDER: _____

HISTORY: INITIAL VISIT - DATE : _____

SEX: F or M HEIGHT: ___ ' ___ " WEIGHT: _____ LBS EYES _____

HAIR: _____ RACE: W _____ B _____ ASIAN _____ HISP _____

LOCATION OF ACCIDENT:

DRIVER: YES .. NO .

PASSENGER: FRONT SEAT BACK SEAT PEDESTRIAN

CAR WAS STRUCK IN: FRONT BACK DRIVER SIDE PASSENGER SIDE

BY: CAR TRUNK VAN BUS OTHER.....

WAS TAKEN TO: HOSPITAL NAME.....

WHEN:

X-RAYS TAKEN: YES .. NO .. AREA:

BY: AMBULANCE..... CAR..... WALK.....

HOSPITALIZED: YES... NO... HOW LONG..... E.R. ONLY.....

LOSS CONSCIOUSNESS: YES ... NO ... HOW LONG

INJURIES SUFFERED:

HEAD: Headaches; Dizziness; Nausea; Vomiting; Blurred Vision

NECK: UPPER BACK: LOWER BACK: CHEST:

UPPER EXTREMITIES:

COLLAR BONE: Rt Lt; SHOULDER: Rt Lt; UPPERARM: Rt Lt;

ELBOW: Rt Lt; FOREARM: Rt Lt; WRIST: Rt Lt;

HAND: Rt Lt;

LOWER EXTREMITIES:

HIP: Rt Lt; THIGH: Rt Lt; KNEE: Rt Lt; LEG: Rt Lt;

ANKLE: Rt Lt; FOOT: Rt Lt

WHAT ARE YOUR COMPLAINTS NOW:

.....
.....

WHAT OTHER DOCTORES HAVE YOU SEEN:

.....

ANY OTHER ACCIDENT OR OPERATION (EVEN IF NOT RELATED)YES... NO.

WHAT & WHEN:

.....

ANY PROBLEMS RELATED WITH: HEART LUNGS STOMACH LIVER

KIDNEYS BLADDER ARE YOU PREGNANT? Yes No NA

ANY ALLERGIES? _____ ARE YOU DIABETIC? Yes No

TAKING ANY MEDICATIONS:

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