ACCIDENT PATIENT INFORMATION

Name_____Date_____

Home Address_____
Address City State Zip
Phone HM ( )_____WK ( )_____CELL ( )_____

What type of injury are we seeing you for?
___Auto ___Work ____Sports Injury ____Other

INSURANCE INFORMATION:

INSURANCE COMPANY FOR BILLING (If not auto accident/workers' compensation injury)
Insurance Company Name_____
Insurance Company Address_____
Insurance Company Phone #_____
Group #_____ Subscribers ID#_____
SubscribersName_____Relationship_____
Subscribers Date of Birth _____Subscribers Employer_____

YOUR AUTO INSURANCE (If auto claim)
Insurance Company Name_____
Address_____
Phone #_____Fax#_____
Claim#_____Policy#_____
Adjusters Name_____

OTHER PARTY'S INSURANCE: (If auto claim)
Insured Name _____
Insurance Company Name _____
Address _____
Phone# _____Fax#_____
Claim#_____Policy#_____
Adjusters Name_____

I understand that Lakewood Chiropractic Offices will work with me (i.e., with my attorney, insurance carrier, if applicable) on a lien basis with payment for services rendered coming from my accident settlement. However, I understand that a good faith payment is expected monthly (minimum $50.00) prior to settlement of the claim. I also understand that payment is expected for any "hard goods" (such as cold packs, supports, supplements, etc.) at the time they are received.

Signature_____ Date _____

Accident Questionnaire

Name _____ Today's Date _____

Date of Accident _____ Location of Accident _____

QUESTIONS ABOUT THE ACCIDENT CIRCUMSTANCES:

Year and make of the vehicle you were riding in _____
Number of vehicles involved _____
Year and make of other vehicle(s) _____
Monetary damage to your vehicle $_____
Monetary damage to other vehicles $_____
Speed of vehicles at impact your vehicle _____vehicle #2_____ vehicle #3_____
Were you the driver or passenger? _____
If passenger, where were you seated in the vehicle?
__passenger seat __rear seat, driver's side __rear seat, passenger side.
Were you wearing a seat belt at the time? ___yes ___no
Was your vehicle moving or stopped? ___moving ___stopped
Did your vehicle strike another vehicle? ___yes ___no
Did another vehicle strike yours? __yes ___no
Where was your vehicle hit? __ front __ rear __ driver's side __ passenger's side
Describe the impact _____
_____
If your vehicle had air bags, did they deploy? _____
What were the road conditions? __ dry __wet __icy __snow packed __other
How far did your car move after impact? car lengths_____ feet_____

QUESTIONS ABOUT YOUR CIRCUMSTANCES AT IMPACT:

Did you see the impact? __ yes __no If yes, did you brace yourself before impact? __yes __no.
Where were you looking? __forward __upward __downward __to the left __to the right
Were you looking in the rear view mirror? __ yes __ no
Were you looking in the side view mirror? __ yes __ no
What was your body position at the time of impact? ___neutral ___ forward ___rotated (right/left)
Which way was your vehicle turning? __ left __ right __ not turning at all
Did you strike another object? __ wheel __ dash __ window
__ other (describe) _____
Did you experience any of the following at the time of impact? __ cuts __ bruises __ abrasions
__ dislocations __ bumps/where?_____ __ nausea __ vision problems
__ immediate dizziness __ altered consciousness __ immediate head pain
___ immediate pain/where? _____
Loss of consciousness/how long? _____

NAME_____ **DATE**_____

QUESTIONS ABOUT YOUR CURCUMSTANCES AFTER THE ACCIDENT:

Were you able to get out of the vehicle and walk on your own? __ yes __ no

Was your car drivable from the scene of the accident? __ yes __ no

Did you go to the hospital, home or return to work? __ hospital __ home __ to work

Who was at fault for this accident? _____

Did police write any tickets? __ yes __ no

If yes, to whom_____

If you went to the hospital, did you stay overnight? __ yes __ no

Were any x-rays taken following the accident? __ yes __ no

If they were taken, what part of your body was x-rayed? _____

Were you instructed on any of following? __ use of ice __ use of heat __ use of medication other_____

How did you feel that night? __ restless __ in pain __ stiff __ sore __ fine

How did you feel the next day? __ better __ same __ worse

Have your complaints kept you from doing anything? __yes __no

If so, what? _____