AUTO ACCIDENT FORM

WELCOME TO 330 CHIROPRACTIC. We specialize in assisting our patients to achieve their highest level of health through our spinal and postural corrective programs. Our approach is very unique and advanced from other chiropractic programs. This allows our patients to achieve far superior results compared to most other systems.

Please fill out the following information thoroughly so the doctor can let you know if you are a case we can accept. Please feel free to ask any questions if you need assistance. We look forward to serving you.

_____

Patient Signature:

_____

Today's Date:

_____

File #:

COLLISION INFORMATION

Name:_____ Today's Date: _____

Where did the collision occur: Street:_____ City:_____ State:_____

Date of accident:_____ Time of accident_____ AM or PM. Was the road: ☐ Dry ☐ Wet ☐ Icy ☐ Other

Were you the: ☐ Driver ☐ Front passenger ☐ Rear passenger ☐ Pedestrian? Number of people in your vehicle_____

Were you struck from ☐ Behind ☐ Front ☐ Left side ☐ Right side Speed of your car:_____ Other car:_____

Describe what happened:_____

_____

_____

_____

CRASH DETAILS

☐ Yes ☐ No If driving, were both hands on the wheel at impact?

☐ Yes ☐ No If passenger, did your hands brace yourself?

☐ Yes ☐ No Were you wearing your seatbelt?

☐ Yes ☐ No Did the airbag engage?

☐ Yes ☐ No Did you hit the dash, steering wheel, window or headrest? If so, which? _____

☐ Yes ☐ No Did you know you were going to be hit?

☐ Yes ☐ No Did you brace yourself with hands or feet?

☐ Yes ☐ No If driving, was your foot on the brake at impact?

☐ Yes ☐ No Was your head turned at impact? If yes, which way? _____

☐ Yes ☐ No Did you get hit into another car, tree, railing, etc.?

☐ Yes ☐ No Were you knocked unconscious?

☐ Yes ☐ No Were the police notified?

What part of the vehicle was hit?_____

Amount of damage to your car?_____

☐ Yes ☐ No Did the accident force you to take any medications? If yes, what?_____

☐ Yes ☐ No Did you see an MD, go to the ER or Urgent Care? If so, when? _____

☐ Yes ☐ No Did you lose any days from work?

☐ Yes ☐ No Did the car that hit you have insurance?

☐ Yes ☐ No Do you have Medical Pay on your car insurance? If so, what dollar amount? ☐ $1,000 ☐ $5,000 ☐ $10,000

☐ Yes ☐ No Did your head hurt after the collision?

1. What make and model of vehicle were you in?_____ The other vehicle?_____
2. Was the headrest positioned: ☐ Below ☐ Level with ☐ Above the center of your head
3. How soon after the collision did you notice any pain? _____
4. Did the crash affect: ☐ Dizziness ☐ Memory ☐ Concentration ☐ Headaches ☐ Balance ☐ Nightmares ☐ Breathing
   ☐ Fatigue ☐ Irritability ☐ Ability To Read ☐ Ability To Listen ☐ Appetite ☐ Nausea ☐ Vision
5. Is there anything else you want us to know?_____

_____

_____

ACCIDENT INSURANCE INFORMATION

Your Auto Insurance Information

Were you driving your own vehicle? ☐ Yes ☐ No

If yes, complete this section:

Insured's Name:_____

Insurance Company:_____

Policy #:_____

Did you report the accident to your insurance? ☐ Yes ☐ No

Claim Adjuster:_____ Adjuster's Phone #_____

Claim #_____

Medpay? ☐ Yes ☐ No Amount:_____

Were you the passenger in the vehicle? ☐ Yes ☐ No

If yes, complete this section:

The Driver's name:_____

Insurance Company: _____

Policy #: _____

Claim Adjuster:_____ Adjuster's Phone #_____

Claim #_____

Medpay? ☐ Yes ☐ No Amount:_____

3rd Party Information

Was the accident your fault? ☐ Yes ☐ No

If no, complete this section:

Other Driver's Auto Insurance Information:

Other Driver's name:_____

Insurance Company:_____

Policy #: _____

Did you report the accident to your insurance? ☐ Yes ☐ No

Claim Adjuster:_____ Adjuster's Phone #_____

Claim #_____

Were you driving someone else's vehicle? ☐ Yes ☐ No

If yes, complete this section:

Vehicle Owner's name:_____

Insurance Company: _____

Policy #: _____

Claim Adjuster:_____ Adjuster's Phone #_____

Claim #_____

Attorney Information

Have you retained an Attorney? ☐ Yes ☐ No

Attorney 's Name:_____

Attorney's Phone #_____

Your Health Insurance Information

Please give insurance card to front desk to copy:

Insurance Name:_____

1nsurance Phone #:_____

Policy Holder Name:_____

Subscriber ID:_____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making my collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse co-issued remittances for the conveyance of credit to my account. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also under- stand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Patient Signature_____ Date _____

(If under age 18) Parent's signature