

First Choice Family Chiropractic

AUTO ACCIDENT INFORMATION FORM - IF YOU NEED MORE SPACE, WRITE ON THE BACK OF THIS PAGE

NAME _____ AGE IN YEARS _____ DATE OF BIRTH _____ SEX _____

MARITAL STATUS _____ HOME PHONE (____) _____

WORK PHONE (____) _____ CELL PHONE (____) _____

ADDRESS _____

E-MAIL Address _____

ACCIDENT DATE _____ TIME _____

WHERE DID IT HAPPEN? _____

GIVE A DETAILED DESCRIPTION OF HOW THIS ACCIDENT INJURY HAPPENED.

_____ WHAT PARTS OF YOUR BODY WERE HURT? _____

HAVE YOU EVER HURT THESE PARTS OF YOUR BODY BEFORE? _____ IF YES, HOW AND WHEN _____

WHERE DO YOU NOW FEEL PAIN? _____

WHAT SYMPTOMS/PROBLEMS BEGAN WHEN YOU GOT HURT? _____

WHAT SYMPTOMS/PROBLEMS DO YOU FEEL RIGHT NOW? _____

HAVE YOU EVER HAD THESE SYMPTOMS/PROBLEMS BEFORE THE ACCIDENT? _____

IF YES, WHEN AND FROM WHAT? _____

WHERE WERE YOU IN THE VEHICLE? _____ WHAT TYPE OF VEHICLE WERE YOU

IN? _____ WHAT WAS THE SPEED OF YOUR CAR AT IMPACT? _____ WERE YOU

ACCELERATING AT IMPACT? _____

WHAT WAS YOUR VEHICLE DOING JUST BEFORE IMPACT? _____

WHAT WAS THE POINT OF IMPACT ON YOUR CAR? _____

HOW MUCH DAMAGE WAS DONE TO YOUR CAR? [] UNKNOWN [] APPROXIMATELY

\$ _____

DESCRIBE THE ROAD CONDITIONS AND VISIBILITY _____

WERE OTHER VEHICLES INVOLVED? _____ HOW MANY? _____ WAS A POLICE

REPORT FILED? _____

WHICH VEHICLE HIT THE OTHER? _____

DID AIR BAGS DEPLOY? _____ DID YOU LOSE CONSCIOUSNESS? _____ GET EMERGENCY

CARE AT SCENE? _____

WHAT WAS THE POSITION OF YOUR HEADREST? _____

WERE YOU WEARING A SEAT BELT? _____

WHAT TYPE OF SEAT BELT _____

IMMEDIATELY AFTER THE ACCIDENT WHERE DID YOU GO OR WHERE WERE YOU TAKEN? _____

WERE YOU PREPARED FOR IMPACT? _____ WAS YOUR FOOT ON THE BRAKE AT IMPACT? _____

DID THE IMPACT KNOCK YOUR FOOT OFF THE BRAKE? _____

WHAT WAS THE POSITION OF YOUR HEAD AND NECK AT IMPACT? _____

WHAT WAS THE OTHER VEHICLE TYPE? _____ SPEED OF OTHER VEHICLE AT TIME OF IMPACT _____

WHAT WAS THE OTHER VEHICLE'S POINT OF IMPACT? _____

WAS THE OTHER VEHICLE ACCELERATING AT IMPACT? _____ WHAT WAS THE OTHER VEHICLE DOING JUST BEFORE IMPACT? _____

LIST ALL THE DOCTORS THAT YOU HAVE BEEN EXAMINED OR TREATED BY SINCE THIS ACCIDENT.
INCLUDE: DOCTOR'S NAME, ADDRESS, TREATMENT YOU WERE GIVEN, REASON FOR TREATMENT, AND WHAT EFFECT DID THE TREATMENT HAD ON YOU?

DID YOU MISS WORK DUE TO THIS ACCIDENT? _____ WHAT IS THE FIRST DATE YOU MISSED _____ HAVE YOU RETURNED TO WORK _____ WHEN? _____ BETWEEN THESE DATES DID YOU DO ANY WORK? _____ IF YES, ON WHAT DATES _____ WAS ANYONE ELSE IN THE CAR WITH YOU? _____ WHO AND WHAT RELATIONSHIP DOES THAT PERSON(S) HAVE TO YOU? _____ HAS THAT PERSON(S) BEEN TREATED DUE TO THIS ACCIDENT? _____ DID YOU REPORT THIS TO YOUR AUTO INSURANCE? _____ IS THERE ANYTHING YOU CAN NOT DO AS A RESULT OF THIS ACCIDENT? PLEASE BE SPECIFIC ABOUT WHAT YOU CAN NOT DO _____

To the best of my knowledge, all information above is accurate and true. I authorize my insurance carrier(s), trustees, executors, accountant, custodian &/or attorney to make payment directly to First Choice Family Chiropractic for services rendered to me/my family by First Choice Family Chiropractic. I agree to pay any balance left unpaid. I authorize First Choice Family Chiropractic to send bills/claims &/or reports for services rendered directly to my insurance carrier &/or attorney and to release to my insurance carrier &/or attorney any information needed to process my claim. I acknowledge that I am completely and fully responsible for paying all fees that I or my family incur with First Choice Family Chiropractic. If I have financial difficulties/hardship, I shall pay First Choice Family Chiropractic according to the terms of any agreement that I make with First Choice Family Chiropractic. This authorization serves as a Doctor's Lien, directing my attorney to withhold from any settlement, judgment, or verdict which may be paid to my attorney or me whatever sum is needed to protect First Choice Family Chiropractic, and to pay First Choice Family Chiropractic directly from those proceeds. If First Choice Family Chiropractic has to resort to collection proceedings against me, I agree to pay all collection costs including the fees of collection agents, attorneys, and court costs, in addition to paying all fees due First Choice Family Chiropractic for services rendered by First Choice Family Chiropractic to &/or for me or my family. I authorize First Choice Family Chiropractic and staff to call me on the telephone to discuss appointments, treatment information, and/or any other details related to my/my family's therapy and treatment. First Choice Family Chiropractic and staff may leave messages about appointments on my answering machine. If I am unavailable or incapacitated, I authorize First Choice Family Chiropractic and/or staff to discuss my case with my spouse, parents, adult children, and/or other health care providers. First Choice Family Chiropractic is authorized to release any and all information requested to any other health care provider involved in my care and treatment.

TODAY'S DATE _____

YOUR SIGNATURE _____

Patient Information

First Name: _____ MI: _____ Last Name: _____

Street: _____ Apt: _____

City: _____ State: _____ Zip: _____

Social Security #: _____ Marital Status: S M W D Spouse: _____

DOB: _____ Home Phone: _____ Work Phone: _____

Cell Phone: _____ Carrier _____ email: _____

Emergency Contact: _____

Whom may we thank for referring you to our office? _____

Occupation: _____ Employer: _____

Employer Address: _____

Insurance Information

We will make a copy of your insurance card/s. However, please complete the following information.

Are you the policy holder? Y N If no, who is policy holder: Spouse Parent Employer Other

Policy Holder's Name:

First Name: _____ M.I. _____ Last Name: _____

Policy Holder's Date of Birth: _____ Policy Holder's SS#: _____

Policy Holder's Employer: _____

Do you have secondary insurance coverage? Y N If yes, please complete the following:

Policy Holder's Name:

First Name: _____ M.I. _____ Last Name: _____

Policy Holder's Date of Birth: _____ Policy Holder's SS#: _____

Policy Holder's Employer: _____

Assignment & Release

Insurance Information

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this doctors office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees or outstanding balances for services I have received will be immediately due and payable.

Patient's/Parent's/Guardian's Signature: _____

Consent of Professional Services and Release of Information

I hereby authorize and release the doctor and whomever he/she may designate as his/her assistants, to administer treatment, physical examination, x-ray studies, laboratory procedures, chiropractic care or any clinic services that he/she deems necessary in my case; I furthermore authorize him/her to disclose all or any part of my patient record to any person or corporation which is or may be liable under a contract to this office or to the patient or to a family member or employer of the patient for all or part of the clinic's charge, including, and not limited to hospital or medical service companies, insurance companies, worker's compensation carriers, welfare funds, or the patient's employer.

Patient's/Parent's/Guardian's Signature: _____