Auto Accident/Personal Injury Form

TODAY'S DATE: _____ REFERRED BY:_____ FILE #
NAME: _____SOCIAL SECURITY # _____
ADDRESS: _____ CITY:_____
STATE_____ ZIP _____ H ( )_____ C ( )_____ W ( )_____
BIRTH DATE: _____ AGE: _____
YOUR AUTO INSURANCE:_____
ADDRESS:_____
CLAIM #_____
RESPONSIBLE PARTY:_____
INSURANCE COMPANY:_____
ADDRESS:_____
CONTACT PERSON:_____ PHONE:_____
FAX:_____
ATTORNEY IF APPLICABLE:_____ PHONE:_____
FAX:_____
ATTORNEY'S ADDRESS:_____
HEALTH INSURANCE:_____ POLICY NUMBER:_____
POLICY HOLDERS NAME: _____
EMPLOYER:_____
HEALTH INS. ADDRESS:_____
NATURE OF THE ACCIDENT
_____
_____
DATE OF ACCIDENT:_____ TIME OF DAY:_____
LOCATION:_____
YOU WERE: DRIVER PASSENGER IN FRONT PASSENGER IN BACK OTHER WORE SEAT BELT
NUMBER OF PEOPLE IN THE CAR:_____
YOU WERE STRUCK FROM THE: ____FRONT ___REAR ____RIGHT SIDE ___LEFT SIDE
YOU STRUCK ANOTHER ON THE: ____FRONT ___REAR ____RIGHT SIDE ___LEFT SIDE
WERE YOU SHOVED FORWARD AND WHIPPED BACKWARDS AT A RAPID FORCE, WHILE HITTING YOUR HEAD?_____
DID YOUR HEAD OVERRIDE THE HEADREST AND SPRINGBOARD FORWARD?_____
DID YOUR HAT AND GLASSES END UP IN THE BACKSEAT OR UNDER THE REAR WINDOW?_____
DID YOU STRIKE ANYTHING IN THE VEHICLE? ____YES ___NO PLEASE SPECIFY:_____
DID YOU REQUIRE IMMEDIATE MEDICAL ATTENTION AT THE SCENE: ___YES ___NO FOR WHAT:_____
DID YOU GO TO THE EMERGENCY ROOM? ___YES ___NO BY AMBULANCE? ___YES ___NO
WHAT HOSPITAL?_____
WHAT WAS DONE TO YOU AT THE HOSPITAL?
_____
ANY MEDICATION PRESCRIBED? ___YES ___NO IF SO, WHAT? _____ _____

PLEASE DESCRIBE HOW YOU FELT IMMEDIATELY AFTER THE ACCIDENT:

_____ _____

HOW DID YOU FEEL A FEW HOURS LATER/THAT NIGHT:_____

HOW DID YOU FEEL THE NEXT DAY:_____

HOW IS YOUR SLEEP QUALITY? _____

HAVE YOU BEEN TREATED BY ANY OTHER PHYSICIANS SINCE THE ACCIDENT? ___YES ___NO IF SO, FOR WHAT:_____ _____

WHAT ARE YOUR PRESENT SYMPTOMS?_____

WHAT GIVE YOU RELIEF? _____ _____

WHAT MAKES YOU WORSE?_____

DOES THE TIME OF DAY AFFECT YOUR SYMPTOMS?_____

DOES POSITION/MOVEMENT AFFECT YOUR SYMPTOMS?_____

ON A SCALE OF 0-10 WITH 0 BEING NO PAIN AND 10 BEING THE WORST PAIN YOU HAVE EVER EXPERIENCED, RATE YOUR PAIN:

NOW _____, ON AVERAGE _____, IN THE MORNING _____, AT NIGHT_____, AT ITS WORSE_____ AT ITS BEST_____

SINCE THE ACCIDENT HAVE YOUR SYMPTOMS: ___IMPROVED, ___GETTING BETTER, ____GETTING WORSE, ____THE SAME

HAVE YOU LOST ANY TIME FROM WORK BECAUSE OF THE ACCIDENT? ___YES ___NO IF YES, HOW LONG:_____

DID YOU HAVE ANY PHYSICAL SYMPTOMS BEFORE THE ACCIDENT? ____YES ____NO IF YES, WHAT WERE THEY:

_____

HAVE YOU HAD ANY OTHER ACCIDENTS PRIOR TO THIS? ___YES ___NO IF YES, WHEN AND WHAT WERE YOUR INJURIES? _____

DO YOU HAVE ANY MEDICAL CONDITIONS FOR WHICH YOU TREAT/CONSULT WITH ANOTHER PHYSICIAN? ___YES ___NO

IF YES, WHO AND FOR WHAT AND WHAT IS THE TREATMENT?

_____

PLEASE CIRCLE THE SYMPTOMS YOU HAVE NOTICED SINCE THE ACCIDENT:

HEADACHES NECK PAIN UPPER BACK MID BACK PAIN LOW BACK PAIN WRIST/HAND HIP PAIN KNEE PAIN ELBOW PAIN ANKLE/FOOT PAIN SHOULDER PAIN CHEST PAIN JAW PAIN RINGING IN EARS BUZZING IN EARS IRRITABILITY TENSION DIZZINESS SHORTNESS OF BREATH STIFF NECK FATIGUE SLEEPING PROBLEMS DEPRESSION NERVOUSNESS HEAD SEEMS HEAVY FAINTING UPSET STOMACH BLURRED VISION PINS/NEEDLES IN LEGS PINS/NEEDLES IN ARMS NUMBNESS IN FINGERS NUMBNESS IN TOES COLD HANDS COLD FEET LOSS OF BALANCE LOSS OF MEMORY

I UNDERSTAND AND AGREE THAT HEALTH AND ACCIDENT INSURANCE POLICIES ARE AN ARRANGEMENT BETWEEN THE INSURANCE COMPANY AND MYSELF. FURTHERMORE, I UNDERSTAND THAT THE DOCTOR'S IN THIS OFFICE WILL PREPARE ANY NECESSARY REPORTS AND FORMS TO ASSIST ME IN MAKING COLLECTIONS FROM THE INSURANCE COMPANY. HOWEVER, I CLEARLY UNDERSTAND AND AGREE THAT ALL SERVICES RENDERED ME ARE CHARGED DIRECTLY TO ME AND THAT I AM PERSONALLY RESPONSIBLE FOR ANY UNPAID BALANCE.

_____ _____

SIGNATURE OF PATIENT OR GUARDIAN IF A MINOR DATE