



VEHICLE COLLISION INFORMATION

FOR OFFICE USE ONLY:

Name: _____ Insurance: _____ File Number: _____ Claim Number: _____

AUTO INSURANCE

NAME OF INSURED	<input type="checkbox"/> Self <input type="checkbox"/> Parent <input type="checkbox"/> Spouse <input type="checkbox"/> Other	INSURANCE COMPANY NAME
POLICY #	CLAIM #	CLAIMS ADDRESS (Where to send bills)
DATE OF COLLISION	TIME OF COLLISION	CITY STATE ZIP CODE
LAWYER (If applicable)	ADJUSTER NAME	ADJUSTER PHONE ()
OTHER DRIVER: <input type="checkbox"/> Don't have their information		DRIVER OF YOUR CAR if other than yourself <input type="checkbox"/> I was the driver
NAME	PHONE #	NAME PHONE #
INSURANCE COMPANY	CLAIM #/ POLICY #	INSURANCE COMPANY CLAIM #/ POLICY #

COLLISION INFORMATION

Please describe the accident in your own words: _____

Were you the: Driver Front Passenger Rear Passenger Pedestrian
How many people were in the accident vehicle? _____

COLLISION SITE

Road/ Street/ Name _____
City/ State _____
Nearest intersection _____
Driving conditions Dry Wet Icy Other _____
Which direction were you headed? _____
Speed you were traveling? _____

VEHICLE

Make and model of vehicle you were in:

Were you wearing a seatbelt? No Yes
If yes, what type? Lap Shoulder
Was the vehicle equipped with air bags? No Yes
If yes, did they inflate properly? No Yes
Did your seat have a headrest? No Yes
If yes, what was the position of the headrest?
 Low Mid-position High
Estimated damage to your vehicle: _____

IMPACT

Did your car hit another vehicle? No Yes
Did your car hit a structure? No Yes
If yes, explain _____
Did any part of your body strike anything in the vehicle?
 Yes No If yes, explain _____
Was collision from:
 Front Rear Left Right Other _____
At the time of the impact were you:
 Looking straight ahead Looking to the right
 Looking to the left Looking down
 Looking up
Were both hands on the steering wheel? No Yes
If no, which hand was on the wheel? Right Left
Was your foot on the brake? No Yes
If yes, which foot was on the brake? Right Left
Were you: Surprised by impact Braced for impact
Were you in pain immediately after the collision? No Yes

FOR OFFICE USE ONLY:

OTHER VEHICLE
(If applicable)

Make and model of other vehicle _____
 Which direction was other vehicle headed? _____

Other passengers in their car? No Yes
 If yes, how many passengers? _____

Involved with an uninsured driver/vehicle
 Involved with more than one vehicle. How many? _____

POLICE

Did the police come to the collision site? No Yes
 Were there any witnesses? No Yes
 Was a police report filed? No Yes
 If yes; the incident number? _____
 Was a traffic violation issued? No Yes
 If yes, to whom? _____

VEHICLE SPEEDS
(Unknown leave blank)

Your Speed: _____ mph Were you? stopped slowing down speeding up unknown
 Was the other vehicle? stopped slowing down speeding up unknown.

AFTER COLLISION

Were you unconscious immediately after the collision? No Yes, If yes, estimate for how long? _____
 Please describe how you felt immediately after the collision:

TREATMENT

Did you go to the hospital? No (skip to next section) Yes If yes, for how long? _____
 When did you go? Immediately after collision Next day 2 days or more after the collision
 How did you get to the hospital? Ambulance Private transportation
 Name of hospital _____ Name of doctor _____
 Treatment received _____ X-rays taken _____
 Diagnosis? Don't know Yes, _____ Medication Received No Yes, list: _____
 Any follow-up visits for your injuries? No Yes If yes, with whom? _____

SYMPTOMS/ INJURIES

Any bleeding or cuts did you get from this collision? None Yes, where _____
 Any bruising from this collision? None Yes, where _____
 As a result of this collision did you suffer from any of the following? Please check all applicable boxes:

<input type="checkbox"/> Arm/ Shoulder pain	<input type="checkbox"/> Anxiety	<input type="checkbox"/> Nervousness
<input type="checkbox"/> Back pain	<input type="checkbox"/> Low back pain	<input type="checkbox"/> Restlessness
<input type="checkbox"/> Back stiffness	<input type="checkbox"/> Sleep disturbance	<input type="checkbox"/> Shortness of breath
<input type="checkbox"/> Chest pain	<input type="checkbox"/> Upper limb numbness/ tingling	<input type="checkbox"/> Sleep difficulty
<input type="checkbox"/> Neck pain	<input type="checkbox"/> Sensitivity to noise	<input type="checkbox"/> Stomach upset
<input type="checkbox"/> Ear buzzing/ ringing of the ears	<input type="checkbox"/> Lower limb pain	<input type="checkbox"/> Difficulty swallowing
<input type="checkbox"/> Headache	<input type="checkbox"/> Impaired concentration	<input type="checkbox"/> Dizziness
<input type="checkbox"/> Fatigue	<input type="checkbox"/> Nausea	<input type="checkbox"/> Forgetfulness
<input type="checkbox"/> Feet/ toe numbness/ tingling	<input type="checkbox"/> Neck pain/ stiffness	<input type="checkbox"/> Upper limb pain
<input type="checkbox"/> Hand/ finger numbness/ tingling	<input type="checkbox"/> Blurred vision	<input type="checkbox"/> Jaw/ facial pain (TMJ)
<input type="checkbox"/> Shoulder pain	<input type="checkbox"/> Irritability	<input type="checkbox"/> Other _____

Was there injury to the other occupant(s) in the vehicle: Yes No Not applicable, I was the only one in the vehicle
 Additional Information (e.g. second impact, cars moving during impact): _____



PERSONAL INJURY POLICY

Personal Injury (*auto accident and personal accidents*) is covered for chiropractic care.

If you have been injured in an accident we will bill your insurance carrier for you. If you have PIP or Early Medical coverage on your auto policy your insurance will cover your care here even if you were not at fault. Your carrier will then be reimbursed by the responsible carrier at the time you settle your claim.

If you have an attorney for your claim please advise our office of the name and address so that we may keep their office up to date on your care and billings from this office.

If you do not have PIP or Early Medical coverage on your auto insurance policy and have only third party as insurance this office requires you to have an attorney for your claim. This is to protect our fees and we will wait to be paid at settlement if you have an attorney and we have the appropriate forms and information regarding the accident. If you choose not to have an attorney in this instance, you may either pay for your care as you go or if you have group medical insurance we will bill them for you.

If you are represented by an attorney we will ask you to sign an Attorney Lien Form authorizing your attorney to withhold from your settlement any amounts still due our office at the time of settlement.

It is quite common for insurance companies to require additional information (*from doctor and patient*) before paying for services. Please notify our office *as soon as possible* so we can help you receive your full benefits under your personal injury policy.

Patient's/Guardian's Name: _____ Date: _____

I fully understand that I am directly and fully responsible for all services rendered to me. I further understand that payment for services is not contingent on any settlement, judgment or verdict by which I may eventually recover.

Patient's Guardian's Name: _____ Date: _____