

VEHICLE ACCIDENT QUESTIONNAIRE

This information will be strictly confidential. Your answers will help us determine if chiropractic care will benefit you. Please print and be as accurate and complete as possible. Thank you.

PATIENT INFORMATION

NAME Last		First	Middle	DATE
ADDRESS		CITY	STATE	ZIP
HOME PHONE	CELL PHONE		BUSINESS PHONE	
SOCIAL SECURITY #	BIRTH DATE	HEIGHT	WEIGHT	SEX
MARITAL STATUS	NO. OF CHILDREN	HOW WERE YOU REFERRED TO OUR OFFICE?		
EMPLOYER	OCCUPATION			
BUSINESS ADDRESS			E-MAIL ADDRESS	

ACCIDENT INFORMATION

GIVE DETAILS OF HOW ACCIDENT OCCURRED:

DATE AND TIME OF ACCIDENT:	<input type="checkbox"/> A.M. <input type="checkbox"/> P.M.	WERE POLICE NOTIFIED?	<input type="checkbox"/> Yes <input type="checkbox"/> No	WERE YOU USING A SEATBELT?	<input type="checkbox"/> Yes <input type="checkbox"/> No	YOU WERE:	<input type="checkbox"/> Driver <input type="checkbox"/> Front Seat <input type="checkbox"/> Passenger <input type="checkbox"/> Back Seat
YOUR VEHICLE WAS HEADING:	<input type="checkbox"/> North <input type="checkbox"/> South <input type="checkbox"/> East <input type="checkbox"/> West	On:	<input type="checkbox"/> Highway <input type="checkbox"/> Street	THE OTHER VEHICLE WAS HEADING:	<input type="checkbox"/> North <input type="checkbox"/> South <input type="checkbox"/> East <input type="checkbox"/> West	On:	<input type="checkbox"/> Highway <input type="checkbox"/> Street
WHERE WERE YOU TAKEN AFTER THE ACCIDENT?	DOCTOR'S NAME:		HOW OFTEN DID YOU SEE THIS DOCTOR?				
WERE YOU UNCONSCIOUS? IF YES, HOW LONG?	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/>	WHAT TREATMENT AND DIAGNOSIS WAS GIVEN?					
IF YOU CONSULTED ANOTHER DOCTOR, GIVE NAME, ADDRESS & PHONE:							
<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/>							

PLEASE DESCRIBE YOUR INJURIES AND SYMPTOMS RESULTING FROM THIS ACCIDENT:

SINCE THIS INJURY, ARE YOUR SYMPTOMS:

Improving The Same Getting Worse

LIST TWO MAJOR COMPLAINTS, AND CIRCLE THE INTENSITY OF PAIN.

	LOW	MOD	INTENSE	EMERGENCY						
COMPLAINT # 1: _____	1	2	3	4	5	6	7	8	9	10
COMPLAINT # 2: _____	1	2	3	4	5	6	7	8	9	10

DID YOU OR ARE YOU STILL TAKING ANY MEDICATIONS FOR THIS INJURY?

No Yes

ANY PRIOR INJURIES OR SYMPTOMS TO THE SAME AREA(S)?

No Yes

HAS INJURY RESTRICTED YOUR WORK? IF YES, IN WHAT WAY?

No Yes

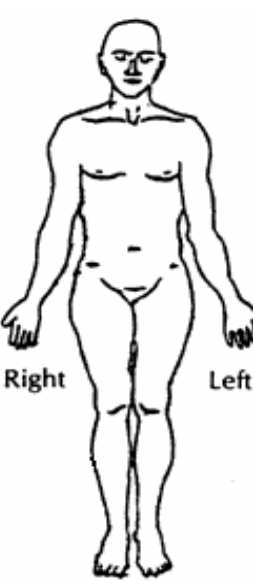
DID YOU RETURN TO WORK? IF NO, HOW LONG WERE YOU OFF?

No Yes

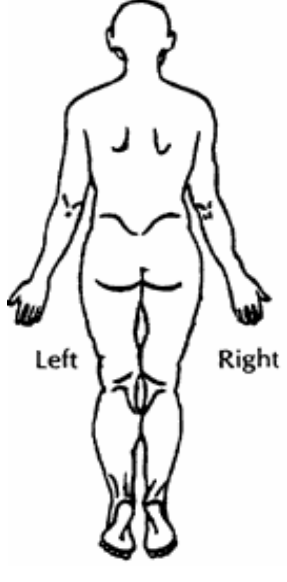
BEFORE THIS INJURY, WERE YOU ABLE TO WORK ON AN EQUAL BASIS WITH OTHERS YOUR AGE?

No Yes

Mark areas of pain resulting from this accident on figures below:



Right Left



Left Right

General Information

The amount of paperwork involved in Personal Injury is rather extensive. However, once completed, billing for your account usually runs smoothly. Thank you for your cooperation. If you have any questions, please ask our staff for assistance.

MASSACHUSETTS LAW

Medical claims for the treatment you receive is paid by the Personal Injury Protection (PIP) portion of the policy of the VEHICLE YOU WERE RIDING IN. We request a copy of the COVERAGE SELECTION PAGE and a copy of the ACCIDENT REPORT for our file to help expedite the processing of your claims.

Your name: _____ Date of Accident: _____
Town/City/State where the accident occurred: _____

Personal Injury Insurance Information

Name of insured person who vehicle you were riding in: _____ Relationship: _____

Their address: _____ City: _____ State: _____ Zip: _____

Name of the above insured's Automobile Ins carrier: _____ Phone #: _____

Address: _____ City: _____ State: _____ Zip: _____

Have you reported your injury to this insurance company? _____ When was it reported? _____

Personal Injury Claim #? _____ What is the adjuster's name? _____

Have you received an application for Personal Injury Benefits from the ins. company? _____ Please complete and mail ASAP.

Please provide copy of the coverage selection page.

IMPORTANT- Amount of deductible chosen under "Personal Injury Protection" portion of Automobile policy: \$ _____

Name of your health insurance company: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone #: _____ Name of insured: _____

Insured's ID #: _____ Insured's Birthday: _____ Relationship to insured: _____

Bodily Injury Carrier Information

If the driver of your vehicle was not at fault in the accident, the other party's insurance carrier is called the Bodily Injury Carrier in this situation.

This carrier may be held responsible to pay your balance due if your own insurance denies paying the full benefits. Please provide this information so that we may look to them for your unpaid balance (if that is necessary at the end of your treatment) before we look to you.

Name of the person driving the other vehicle involved: _____

Name of their Auto Insurance Carrier: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone #: _____ Claim #: _____

Do you have an attorney? _____ Attorney's Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone #: _____ Fax #: _____

Assignment and Release

Our office is willing to accept your insurance assignment as soon as your coverage is verified. It must be understood that your insurance contract is between you and your insurance carrier. Our office does not guarantee that your insurance co. will pay your bill. You are required to sign a "Lein" on your first visit. HOWEVER IF, FOR ANY REASON YOUR CLAIM IS DENIED BY YOUR INSURANCE CARRIER YOU ARE ULTIMATELY AND FULLY RESPONSIBLE FOR YOUR BILL.

PLEASE PHONE AHEAD IF YOU ARE UNABLE TO MAKE A SCHEDULED APPOINTMENT. If you are treating for a Motor Vehicle accident and continually fail to make scheduled appointments, you will be discharged. If you have been out of work it will be assumed that you are no longer disabled and are fully able to return to work.

Patient's Signature: _____ Date: _____

Doctor's Signature: _____ Date: _____