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Auto Accident Questionnaire

Patient Name: _____

Today's Date: ___/___/___

Patient Birthdate: ___/___/___

1. What was the date of the accident? _____
2. What time did the accident occur? _____
3. How many vehicles were involved in the accident? _____
4. What was the estimated damage to the vehicle you were in? _____
5. What street or intersection were you on when the accident occurred? _____
6. What direction were you traveling? (i.e. North, South) _____
7. What city and state did the accident occur in? _____
8. What type of impact was the auto accident? _____
9. In your own words, explain what happened DURING the accident? _____

10. In your own words, explained what happened AFTER the accident? _____

11. Where were you located in the vehicle during the accident? _____
12. Did you know the accident was about to happen? _____
13. What type of vehicle were you in? _____
14. If a second vehicle was involved, what type was it? _____
15. At the time of the impact, your vehicle was (choose one):
 Slowing down ___ mph Gaining speed ___ mph Moving at a steady speed ___ mph
 Stopped Other _____
16. During and after the crash what happened to your vehicle? (Mark all that apply)
 kept going straight spun around
 kept going straight hitting a car in front spun around and hit a stationary object
 was hit by another vehicle hit a stationary object
17. Did your airbags deploy as a result of the accident? Yes No
18. Did you lose consciousness during the accident? Yes No

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19. How was your head positioned during the accident? (i.e. forward, looking right) _____
20. How was your torso positioned during the accident? _____
21. How were your hands positioned during the accident? _____
22. Did your head hit anything during the accident? No Yes, please describe _____
23. Did your face hit anything during the accident? No Yes, please describe _____
24. Did your shoulders hit anything during the accident? No Yes, please describe _____
25. Did your neck hit anything during the accident? No Yes, please describe _____
26. Did your chest hit anything during the accident? No Yes, please describe _____
27. Did your hips hit anything during the accident? No Yes, please describe _____
28. Did your knees hit anything during the accident? No Yes, please describe _____
29. Did your feet hit anything during the accident? No Yes, please describe _____
30. What kind of headrest was in your vehicle?
 movable fixed headrest non-movable fixed headrest no headrest
31. Where was the headrest positioned on your head? High Mid Low Other: _____
32. Did you have your seatbelt on during the accident? Yes No
33. Did you slide out of your seatbelt during the accident? Yes No
34. What was damaged in your vehicle? (Circle all that apply)
 windshield mirror front left door
 steering wheel knee bolster front right door
 dashboard rear bumper back left door
 seat frame front bumper back right door
 side window trunk not applicable
 rear window completely totaled
35. Choose the items on the inside of the vehicle that dented inward:
 floorboards side door dashboard other _____
36. Choose the doors that would not open as a result of the accident:
 front left front right all the doors worked fine
 rear left rear right
37. Did you go to the hospital? Yes No

38. How did you get to the hospital? _____
39. What was the name of the hospital? _____
40. Were you hospitalized overnight? Yes No

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41. Mark what you were prescribed at the hospital:

- pain medication muscle relaxers neck brace back brace told to see a chiropractor
 told to see your doctor Other _____

42. Did you receive any stitches for any cuts at the hospital? If yes, please list locations. Yes No

43. Were x-rays taken at the hospital? If yes, which area(s) was taken? _____

44. Did they do an MRI? If yes, which area(s) were viewed? _____

Driver's Auto Insurance Information

1. Name of the Driver of vehicle you were riding in? _____ Relationship or Self: _____

Driver address: _____ City: _____ State: _____ Zip: _____

2. Name of the Driver's Automobile Insurance carrier: _____ Phone #: _____

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

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

4. Personal Injury Claim #? _____

5. What is the adjuster's name & phone number? _____

6. Have you received an application for Personal Injury Benefits from the ins. company? _____ *If so, please complete and mail ASAP.*

Patient's Auto Insurance Information

Check here if this is the same as the above

1. Name of the Patient/s Automobile Insurance carrier: _____ Phone #: _____

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

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

3. Personal Injury Claim #? _____

4. What is the adjuster's name & phone number? _____

5. Have you received an application for Personal Injury Benefits from the ins. company? _____ *If so, please complete and mail ASAP.*

Health Insurance Information

1. Name of your health insurance company: _____ Phone #: _____

2. Name of insured: _____ Insured's Date of Birth: ___/___/___ Relationship to insured: _____



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IRREVOCABLE DOCTOR'S LIEN AND ASSIGNMENT OF RIGHT TO RECOVERY

In consideration and exchange for not having to immediately pay a debt owed and in consideration for receiving future care at or by Heresco Chiropractic and the doctors whose letterhead this document is printed Heresco Chiropractic Clinic, I, the undersigned, hereby assign and convey to the Clinic a legal and equitable interest in any and all causes of action or rights of recovery I may have arising out of that certain accident or injury-producing event which occurred on or about the _____ day of _____ 20____, to the full extent of the cost and treatment provided or to be provided to me by the clinic.

I hereby authorize and direct my attorney's to hold in trust, and to pay directly to the Clinic such sums as may be due and owing the Clinic for treatment and other professional services rendered me both by reason of this accident and by reason of any other bills that are due the Clinic and to withhold such sums from any settlement judgment or verdict as may be necessary to adequately pay and protect the Clinic. I hereby further give, grant ,and convey a lien on my case to the Clinic against any and all proceeds of any and all causes of action, settlements, judgments, or verdicts which may be paid to or through my attorney, or myself, as the result of the injuries or conditions for which I have been treated by the Clinic.

I fully understand that I am directly and fully responsible to the Clinic for all bills incurred for services rendered me and that this agreement is made solely for the Clinic's additional protection and in consideration for the Clinic's waiting for payment. I further understand that payment for services rendered by the clinic is not contingent on any settlement, judgment, or verdict by which I may eventually recover. I am personally responsible for my bills, regardless of the outcome of any legal claim or case.

I fully understand if my attorney(s) does/do not protect the Clinic's interest, the Clinic may require me to make payments on a current basis. The Clinic may also bring a cause of action against my attorney(s) for failing to honor this binding and irrevocable agreement between me and the clinic.

I further understand and agree that the Clinic is not responsible for paying any of my attorneys fees and the Clinic does not agree to pay my attorney(s) and attorney fees for honoring this agreement between me and the clinic.

" I HAVE READ AND FULLY UNDERSTAND THIS DOCUMENT, AND I AM VOLUNTARILY SIGNING THIS DOCUMENT. I AM DIRECTING MY ATTORNEY(S) TO PROTECT THE CLINIC AND DOCTOR'S INTEREST AT TIME OF SETTLEMENT, AND I AM ASSIGNING AND CONVEYING CERTAIN LEGAL RIGHT OVER TO THE CLINIC. I ALSO KNOW I MAY NOT REVOKE THIS AGREEMENT AT ANY TIME WITHOUT PRIOR WRITTEN AUTHORIZATION FROM THE CLINIC. I UNDERSTAND THAT, AMONG OTHER THINGS, THIS IS A BINDING AND ENFORCEABLE CONTRACT, ASSIGNMENT, AND LIEN."

Signature

Today's Date

Patient Name (Printed)

Patient Birthdate: ___ / ___ / ___