Advanced CHIROPRACTIC

Auto Accident Questionnaire

Kevin Ross, D.C.
Brandy Careri, D.C.

Your Name: _____

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 did the accident occur in? _____
8. What state did the accident occur in? _____
9. Describe the direction of impact. What vehicle(s) hit in what way? _____

   _____

10. What did your vehicle do after the accident?
    - ☐ Hit guardrail ☐ Hit a tree ☐ Rolled over
    - ☐ Ran off the road ☐ Not Applicable ☐ Other _____
11. Which seat of the vehicle were you in 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 you lose consciousness during the accident? Yes No

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18. How was your head positioned during the accident? (i.e. forward, looking right)_____

19. How was your torso positioned during the accident? _____

20. How were your hands positioned during the accident? _____

21. Did your head hit anything during the accident? No Yes, please describe_____

22. Did your face hit anything during the accident? No Yes, please describe_____

23. Did your shoulders hit anything during the accident? No Yes, please describe_____

24. Did your neck hit anything during the accident? No Yes, please describe_____

25. Did your chest hit anything during the accident? No Yes, please describe_____

26. Did your hips hit anything during the accident? No Yes, please describe_____

27. Did your knees hit anything during the accident? No Yes, please describe_____

28. Did your feet hit anything during the accident? No Yes, please describe_____

29. What kind of headrest was in your vehicle?
    - ☐ movable fixed headrest
    - ☐ non-movable fixed headrest
    - ☐ no headrest

30. Where was the headrest positioned on your head? High Mid Low Other: _____

31. Did you have your seatbelt on during the accident? Yes No

32. Did you slide out of your seatbelt during the accident? Yes No

33. What was damaged in your vehicle? (Circle all that apply)
    - ☐ windshield
    - ☐ steering wheel
    - ☐ dashboard
    - ☐ seat frame
    - ☐ side window
    - ☐ rear window
    - ☐ mirror
    - ☐ knee bolster
    - ☐ rear bumper
    - ☐ front bumper
    - ☐ trunk
    - ☐ completely totaled
    - ☐ front left door
    - ☐ front right door
    - ☐ back left door
    - ☐ back right door
    - ☐ not applicable

34. Choose the items on the inside of the vehicle that dented inward:
    - ☐ floorboards
    - ☐ side door
    - ☐ dashboard
    - ☐ other _____

35. 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

36. Did you go to the hospital? Yes No

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37. How did you get to the hospital?

If not, you do not answer questions 37-43.

_____

38. What was the name of the hospital? _____

39. Were you hospitalized overnight? Yes No

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40. 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_____

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

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

43. 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: _____

3. Insured's ID #: _____ Group #:_____

Thank you so much for taking the time to complete this form.
This form will help the doctor to better serve you with your health care needs.

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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 Advanced Chiropractic and the doctors whose letterhead this document is printed Advanced 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 AUTHRIZATION FROM THE CLINIC. I UNDERSTAND THAT, AMONG OTHER THINGS, THIS IS A BINDING AND ENFORCEABLE CONTRACT, ASSIGNMENT, AND LIEN."

_____
Patient Name (Printed)

_____ _____
Signature Date

_____ _____
Insurance Dept. Witness Date