



# Auto Accident Questionnaire

Kevin Ross, D.C.  
Jason Orey, 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

# Auto Accident Questionnaire

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       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
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
- 
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

# Auto Accident Questionnaire

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.





Kevin Ross, D.C.  
Jason Orey D.C.

**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 AUTHORIZATION 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