Sunset Hills Chiropractic • Freedom Chiropractic

Dr. Brittany Warren, DC • Dr. Nathan Free, DC

Motor Vehicle Accident Paperwork

Patient Name: ____ **Today's Date**: ___ / ___ / ___

Birthdate: ___ / ___ /___ **Age:** ___________ **Gender:** F M

Address: ____**City**: _________________**State:** _________

Phone: (_____)________________ **Cell:** (_____)_________________

Emergency Contact: ____ **Phone:** (_____)___________________

Occupation: ____ **Employer:**___________________________________

Who may we thank for referring you to our office? ____

Who is your Primary Care Physician: ___________________________________**Phone:** (____)______________

Accident Information

Date of Accident: ___/___/___ **Time of Accident:**___________ am/pm ◻ Daylight ◻ Dawn ◻ Dusk ◻ Dark

Road conditions at the time of the accident: ◻ Wet ◻ Dry ◻ Snow ◻ Ice ◻Other:____________________________

Was the accident on the job? ◻ Yes ◻ No **Were you in a company vehicle?** ◻ Yes ◻ No

Where were you seated in the vehicle? ◻ Driver ◻ Passenger ◻ Rear-seat ◻ Other:___________________________

Were you aware of the approaching collision prior to impact, or did it catch you by surprise? ◻ Aware ◻ Surprised

Did you lose consciousness upon impact? ◻ Yes ◻ No

Did you experience a flash of light or explosion in your head? ◻ Yes ◻ No

Were the Police notified of the accident? ◻ Yes ◻ No **Is there a Police Report?** ◻ Yes ◻ No

Did you go to the hospital? ◻ Yes ◻ No **When?** ◻ Immediately ◻ ____hours later ◻ _____days later

Which hospital? ____

What did the hospital do for your injuries? (Collars, splints, x-rays, medication etc.) ____________________________

What areas were x-rayed? ______________________________**What was their Diagnosis?**_______________________

What did they recommend for follow-up care?____

Was any other doctor consulted after your car accident? ◻ Yes ◻ No **If yes, please complete information below.**

Dr.___________________________**Specialty?**___________________________**Date first seen:**___/___/___

Type of Treatment:_____________________**Frequency?**____________________**Length:**________________

Dr.___________________________**Specialty?**___________________________**Date first seen:**___/___/___

Type of Treatment:_____________________**Frequency?**____________________**Length:**________________

Were you wearing a seatbelt? □ Yes □ No **If yes, did you receive any injury or bruise from the seat belt?** □Yes □No

Did you head hit the head rest during the accident? □ Yes □ No

If adjustable, was the position of the head rest altered? □ Yes □ No

Was the seat adjustment altered by the accident? □ Yes □ No **Was the seat broken by the accident?** □ Yes □ No

Did the air-bag deploy? □ Yes □ No **If yes, did it strike you?** □ Yes □ No **If yes, where?** ______________________

Which way was your head pointing at the point of impact? □ Straight □ Right □ Left **Body?** □ Straight □ Right □ Left

Where were your hands? □ One on the wheel □ Both on the wheel □ Not applicable

Were you wearing a hat or glasses at the time of impact? □ Yes □ No

If so, were they still on after the accident? □ Yes □ No

Please describe how the accident took place: ____

____

____

____

Your Car

List the year, make and model of the car you were in: Year: _________ Make: _________ Model:________________

Was your car stopped at the time of impact? □ Yes □ No **If yes, was the driver's foot on the brake** □ Yes □ No

If no, estimate the speed of the vehicle you were in: _________mph

If your vehicle was moving at the time of impact, was it: □ Slowing Down □ Gaining Speed □ Steady Speed

Other Car

List the year, make and model of the other car: Year: _______________ Make: _________ Model:________________

Was the other car stopped at the time of impact? □ Yes □ No

Estimate the speed of the vehicle of the other car: __________mph

At the time of impact, was the other car: □ Slowing Down □ Gaining Speed □ Steady Speed

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Automobile Insurance Information

Driver of the automobile you were in: ____________________**Name of their auto insurance:**____________________

Policy #:______________________________________**Claim #:**____

Auto Insurance Phone#:(____)________________**Name of Insurance Adjustor:**_______________________________

Address: ____

Driver of other vehicle: ________________________________**Name of their auto insurance:**____________________

Policy #:______________________________________**Claim #:**____

Auto Insurance Phone#:(____)________________**Name of Insurance Adjustor:**_______________________________

Address: ____

Have you retained an attorney?: □ Yes □ No **Name:** _______________________**Phone:** (____)_________________

Verification form – PIP/Medpay

Does the Above-Referenced Policy contain Medpay or PIP benefits? □ Medpay □ PIP □ Neither

Was the coverage effective at the time of the accident? Yes No **If no, date coverage terminated** ___/___/___

Is there a claim for personal injury on file? Yes No **If yes, personal injury claim #:**____________________________

If the patient retains an attorney, will you still honor our assignment/lien and send payment to our office? Yes No

Maximum Dollar Amount of Medpay per Accident: $_______________ **How much Met?** $_____________________

Name and address of where we should send claims:

Insurance Carrier: ____________________________________**Adjustor:**_____________________________

Address:____

Phone: (____)___________________ **Fax**: (_____)________________________

Patient Condition

At the time of the accident, did you become or experience any of the following:

□ Confused □ Disoriented □ Light Headed □ Dizzy □ Nauseated □ Blurred Vision □ Ringing/Buzzing in Ears

□ Loss of Balance □ Other: ____

Do you still have any of these symptoms? Yes No **If yes, which ones?**_______________________

Check any symptoms you have had since the accident occurred:

□ Headache	□ Dizziness	□ Light Sensitivity	□ Diarrhea	□ Head Feels Heavy
□ Loss of Memory	□ Clumsiness	□ Feet Cold	□ Stiff Neck	□ Tingling Arms/Hands
□ Sleeping Problems	□ Face Flushed	□ Hands Cold	□ Nausea	□ Back Pain
□ Buzzing Ears	□ Loss of Balance	□ Constipation	□ Nervousness	□ Ears Ring
□ Shortness of Breath	□ Fainting	□ Fever	□ Tension	□ Fatigue
□ Chest/Rib Pain	□ Arm/Hand Pain	□ Loss of Smell	□ Jaw Pain	□ Cold Sweats
□ Loss of Strength – Arms	□ Burning Muscle Pain	□ Loss of Strength - Legs	□ Difficulty Swallowing	□ Irritability
□ Sharp/Shooting Pain	□ Leg/Foot Pain	□ Numb Legs/Feet	□ Numb Arms/Hands	□ Tingling Legs/Feet
□ Neck Pain	Other: ______________________			

Smoker? □ Former □ Never □ Current **Number of Packs per Day**: ______________________

Do you Drink Alcohol? □ Yes □ No **Quantity/Frequency**: ______________________

Caffeine Intake (Quantity/Frequency): ______________________________

Medication List (Name of Medication, Dosage, Frequency):

______________________ ______________________

______________________ ______________________

______________________ ______________________

WOMEN ONLY:

Are you pregnant or is there any possibility you may be pregnant? □ Yes □ No □ Uncertain

If checked YES, what is the estimated due date? ___/___/___

Are there any known pregnancy complications? ______________________

Please Mark on the Body Chart where your pain is located.

What Aggravates It? ___________________________________

____

What Relieves It? ___________________________________

____

Please rate the intensity of your pain (0 being no pain, 10 being extreme pain)

No Pain — Moderate Pain — Worst Pain

0 1 2 3 4 5 6 7 8 9 10

0 2 4 6 8 10

I understand the information contained within this form and guarantee this form was completed correctly and to the best of my knowledge.

Patient's signature: _______________________________________ Date: ____/____/____

CONSENT TO TREAT A MINOR: **I hereby authorize the doctor(s) at *Sunset Hills Family Chiropractic · Freedom Chiropractic* to administer care to my child.**

Name of Child/Minor (Please Print)____

Name of Parent/Guardian (Please Print) ____

Parent/Guardian Signature: _______________________________________Date: ____/____/____