AUTO / WORK RELATED ACCIDENT

one

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ABOUT YOU

Today's Date: ___/___/___ File #: _____

Name: _____

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AUTO RELATED ACCIDENT

Date & Time of Accident: _____ ❑ a.m. ❑ p.m.
Were you the: ❑ Driver ❑ Front Passenger ❑ Rear Passenger
If a traffic violation was issued, to whom was it issued?

_____

Number of people in accident vehicle? _____
Did the police come to the accident site? . . ❑ Yes ❑ No
Was a police report filed? . . . . . ❑ Yes ❑ No
Were there any witnesses? . . . . . ❑ Yes ❑ No
Were you wearing your seat belt? . . . . . ❑ Yes ❑ No
Was this vehicle equipped with airbags? . . ❑ Yes ❑ No
If yes, did it/they inflate? . . . . . ❑ Yes ❑ No
In relation to the base of your skull, where was the headrest? . . . . . ❑ Above ❑ Below ❑ At base of skull
What did your vehicle impact? ❑ Another vehicle ❑ Other

If other, explain: _____
Did any part of your body strike anything in the vehicle? ❑ Yes ❑ No

If yes, please describe: _____

_____

Make & model of the vehicle you were occupying?

_____

Name of the location/street on which you were traveling?

_____

In which direction were you headed? ❑N ❑S ❑E ❑W

What was the approx. speed of your vehicle? _____
Did the impact to your vehicle come from the:
❑ Front ❑ Rear ❑ Right Side ❑ Left Side ❑ Other
During impact, were you facing: ❑ Right ❑ Left ❑ Forward
Were you ❑ aware or ❑ surprised by the impact?
If accident vehicle made impact with another vehicle...
Make and model of that other vehicle? _____

_____

Direction other vehicle was headed? ❑N ❑S ❑E ❑W

Speed of the other vehicle? _____

In your words, please describe the accident: _____

_____

_____

_____

PLEASE CONTINUE ON BACK

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AFTER INJURY

Did accident render you unconscious? . . . . . ❑ Yes ❑ No

If yes, for how long?_____

Please describe how you felt immediately after the accident:

_____

_____

Have you gone to a Hospital or seen any other Doctor? ❑ Yes ❑ No

When did you go? ❑ Just after accident ❑ The next day ❑ 2 days plus

How did you get there? ❑ Ambulance or ❑ Private transportation

Name of Hospital and/or Attending doctor: _____

_____

Was he/she a: ❑ D.C. ❑ M.D. ❑ D.O. ❑ D.D.S.

Describe any treatment you received: _____

_____

Were X-rays taken? . . . . . ❑ Yes ❑ No

Was medication prescribed? . . . . . ❑ Yes ❑ No

Have you been able to work since this injury? ❑ Yes ❑ No

Are your work activities restricted as a result of this injury? ❑ Yes ❑ No

Indicate ☑ the symptoms that are a result of this accident:

❑ Dizziness	❑ Difficulty sleeping	❑ Jaw problems	❑ Nausea
❑ Memory loss	❑ Irritability	❑ Arms/Shoulder pain	❑ Back pain
❑ Headache(s)	❑ Fatigue	❑ Numb Hands/Fingers	❑ Lower back pain
❑ Blurred vision	❑ Tension	❑ Chest pain	❑ Back stiffness
❑ Buzzing in ear	❑ Neck pain	❑ Shortness of breath	❑ Leg pain
❑ Ears ringing	❑ Neck stiff	❑ Stomach upset	❑ Numb Feet/Toes

❑ Other _____

Is your condition getting worse?

❑ Yes ❑ No ❑ Constant ❑ Comes & goes

Indicate your degree of comfort while performing the following activities:

	Comfortable	Uncomfortable even if only sometimes	Painful
Lying on back	❑	❑	❑
Lying on side	❑	❑	❑
Lying on stomach	❑	❑	❑
Sitting	❑	❑	❑
Standing	❑	❑	❑
Stretching	❑	❑	❑
Lovemaking	❑	❑	❑
Walking	❑	❑	❑
Running	❑	❑	❑
Sports	❑	❑	❑
Working	❑	❑	❑
Lifting	❑	❑	❑
Bending	❑	❑	❑
Kneeling	❑	❑	❑
Pulling	❑	❑	❑
Reaching	❑	❑	❑

Have you retained an attorney: ❑ Yes ❑ No

If yes, whom: _____

His/Her Phone #: _____

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RECOVERY

To evaluate the effect that continuing work will have on your recovery please complete the following:

How many hours are in your normal work day? _____

Please indicate ☑ your daily job duties and any activities which you are occasionally asked to perform.

❑ Standing	❑ Driving	❑ Operating equipment
❑ Sitting	❑ Twisting	❑ Work with arms above head
❑ Walking	❑ Crawling	❑ Typing
❑ Lifting	❑ Bending	❑ Stooping

❑ Other _____

What positions can you work in with minimum physical effort and for how long? _____ ❑ N/A

Prior to the injury were you capable of working on an equal basis with others your age? . . ❑ Yes ❑ No ❑ N/A

Do you work with others who can help you with any heavy lifting? . . . . . ❑ Yes ❑ No ❑ N/A

While in recovery, is there any light duty work you could request? . . . . . ❑ Yes ❑ No ❑ N/A

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ADDITIONAL INSURANCE

2nd Insurance Source or Auto Insurance

Type of Insurance: _____

Co. Name: _____

Address: _____

Phone #: _____

Insured's Name: _____

Policy #: _____ Claim #: _____

Insured's SS #: _____ D.O.B. ___/___/___

Insured's Employer: _____

Agent's Name: _____

If any of your medical or account information has changed, please inform our front desk personnel.

Please remember you are ultimately responsible for your account.

_____ ___/___/___

SIGNATURE DATE

OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY

PLEASE RECYCLE SO THAT WE MAY PRESERVE THE HEALTH OF OUR PLANET

MOTOR VEHICLE ACCIDENT
ASSIGNMENT OF BENEFITS

ASSIGNMENT OF BENEFITS

To Insurance Company: I hereby direct and instruct you to make payment to CHARLES E. HOLTON, JR., D.C. for medical claims submitted by them on my behalf for medically necessary treatment.

Your denial or delay to do so in a timely manner will be considered just cause for myself or my provider to file a complaint with the Insurance Commissioner. I hereby give my permission to the provider(s) to file this complaint on my behalf if deemed necessary.

Patient Initial Here:_____

Your insurance contract is an agreement between the insurance company and yourself. CHARLES E. HOLTON, JR., D.C. is willing to prepare the necessary reports and assist in collecting from the insurance company that which is due to me for your medically necessary care and treatment. I understand that I am responsible for paying any balance not paid by the insurance company and authorize the release of any information to collect payment.

Patient's Name (Print)_____

Patient's Signature_____Date_____

Insurance Information

Please complete the following so that we can bill your insurance.

_____ _____

Insurance Company Name **Date of Accident**

_____ _____

Insurance Company Address **Claim Number**

_____ _____

Insurance Company City, State, Zip Code **Attorney (if applicable)** **Phone No.**

_____ _____

Insurance Company Phone Number **Referring Physician** **Phone No.**

_____

Insurance Adjuster