Automobile Accident Questionnaire

Please answer all questions completely

This information is considered confidential. We need this information because we care enough to want to know and your answers will help us determine if chiropractic can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. In order for us to understand your condition properly, please be as neat and accurate as possible while completing this form. Thank you.

Name_____ Date of Birth_____

*Date of accident*_____ *Where did the accident occur?*_____

Please explain, in detail, how the accident happened:

_____

_____

_____

Were you the □ Driver? □ Front seat passenger? □ Back seat passenger?

What direction were you looking at the time of impact?_____

Were you aware of the impending impact? □ Yes □ No

Were you wearing a seatbelt? □ Yes □ No

Was there a headrest behind your head? □ Yes □ No *If yes, how far above/below your head was it?*_____

Did your body hit any part of the vehicle? □ Yes □ No *If yes, what did you hit?*_____

You were heading □North □South □East □West on _____(St/Hwy)

Other vehicle was headed □ North □ South □ East □ West on _____(St/Hwy)

Were you struck from □ Behind □ Front □ Left side □ Right side

Were you knocked unconscious? □ Yes □ No If yes, for approximately how long?_____

Did you feel pain immediately after the impact? □ Yes □ No If yes, where did you feel the pain? _____

_____

Did the police come to the accident? □ Yes □ No

Did you receive a citation? □ Yes □ No

Did the driver of the other vehicle? □ Yes □ No □ Unknown

Were you taken to the hospital? □ Yes □ No Did they take x-rays? □ Yes □ No

Have you seen any other doctors, prior to seeing us, since the accident? □ Yes □ No *If so, what was the doctor's name and* diagnosis_____

What treatment was given?_____

How often did you see the doctor?_____

How long did you see the doctor?_____

Have you ever had any complaints in the involved area before? □ Yes □ No If so, what were the complaints_____

Before the injury were you capable of working on an equal basis with others your age? □ Yes □ No

Are your work activities restricted as a result of this accident? □ Yes □ No

Since this injury are your symptoms □ Improving? □ Getting worse? □ Same

**I attest that the information provided is true & correct to my knowledge, & understand that intentionally providing false or misleading information constitutes fraud.

_____

Patient Signature Date

Personal Injury Insurance Information

Your Insurance Company	
Insurance Company Phone Number	
Your Policy Number	
Claim Number	
Personal Injury Protection Coverage?	Yes No Agent & Date Confirmed_____
Claims Adjuster	

Responsible Party's Insurance Company	
Insurance Company Phone Number	
Policy Number	
Claim Number	
Personal Injury Protection Coverage?	Yes No Agent & Date Confirmed_____
Claims Adjuster	

Name of Attorney	
Attorney Phone Number	
Other Information:	

PERSONAL INJURY PROTECTION (PIP) VERIFICATION AGREEMENT

Due to HIPPA privacy regulations, Naturally Chiropractic cannot contact your auto insurance company for verification of the dollar amount of Personal Injury Protection Medical Benefits available for you on your auto accident claim. You must contact your auto insurance carrier directly for this information. To protect you from accruing a balance exceeding your PIP benefits for services rendered at Naturally Chiropractic, we request that you contact your auto insurance company (after 24 chiropractic adjustments, or 60 days of chiropractic care -whichever comes first) to verify the level of PIP benefits on your policy, and the remaining amount of PIP benefits available. By signing this form, you agree to contact your insurance company for the information described above, and to keep Naturally Chiropractic informed of any communications with your auto insurance company regarding your care, PIP benefits, independent medical examinations, and reports. This enables Naturally Chiropractic to have the most current information regarding your claim, and to avoid claim and payment issues later.

I have read, understand and agree to the above policy.

Printed Name	Signature	Date

STOP HERE

THIS SECTION TO BE COMPLETED AFTER 24 VISITS/60 DAYS

Your Insurance Company: _____

Your Claim Number: _____

Your Claim Adjuster: _____

Phone Number: _____

Personal Injury Protection Benefit Amount on Your Policy

$_____

Benefit Amount Available

$_____ **as of (Date)**_____

Name of Person You Spoke to: _____