Automobile Accident Patient Information

PATIENT

Name: ________________ S.S #________________ Home#: ________________

Address:________________ City: ________________ State: _____ Zip:__________

E-mail: ________________ Cell#:________________ Age: ________ Birth Date: __________

Circle Marital Status: Married Single Widow Divorced Separated How many children? __________

WOMEN ONLY Are you, or is there any possibility that you may be pregnant? Yes❑ No❑ Uncertain❑

How did you hear about our office? ________________

EMPLOYER

Occupation: ________________ Company Name: ________________

Address: ________________ Phone#: ________________

EMERGENCY CONTACT

Name:________________ Relationship:________________

Address:________________ Phone#:________________

ACCIDENT INFORMATION

Date of Accident: __________ Time: __________ Location:________________ Was Police notified? Yes❑ No❑

Where you the: Driver ❑ Front Seat Passenger ❑ Back Seat Passenger ❑

Number of people in your vehicle? __________ Were you wearing seat belts? Yes❑ No❑

Approximate speed of your vehicle: __________mph Other vehicle: __________mph

Where you knocked unconscious? Yes❑ No❑ If yes for how long?________________

Please describe how you felt during the accident? ________________

Immediately after the accident ? ________________

Later that day?________________

The next day? ________________

Where you taken to the Hospital? Yes❑ No❑ If yes where? ________________ By ambulance? Yes❑ No❑

Have you seen another doctor for this accident? Yes❑ No❑ If yes by who? ________________

As a result of the accident, are you taking medications? Yes❑ No❑ If yes what? ________________

Have you lost time from work due to this accident? Yes ❑ No ❑ If yes what dates? ________________

Are you being paid for time lost from work? Yes ❑ No ❑ If yes by who? ________________

Do you have an ATTORNEY: Yes❑ No❑ If yes who?: ________________

Address:________________ Phone#:________________ Fax#:________________

INSURANCE

Your Ins. Co.________________ Phone#:________________ Agent Name:________________

Name on Policy________________ Policy#:________________ Claim#:________________

RESPONSIBLE Party's Name: ________________ Phone: ________________

Ins. Co.:________________ Phone#: ________________ Agent Name: ________________

Name on Policy________________ Policy#:________________ Claim#:________________

What are your PRESENT complaints?____

____

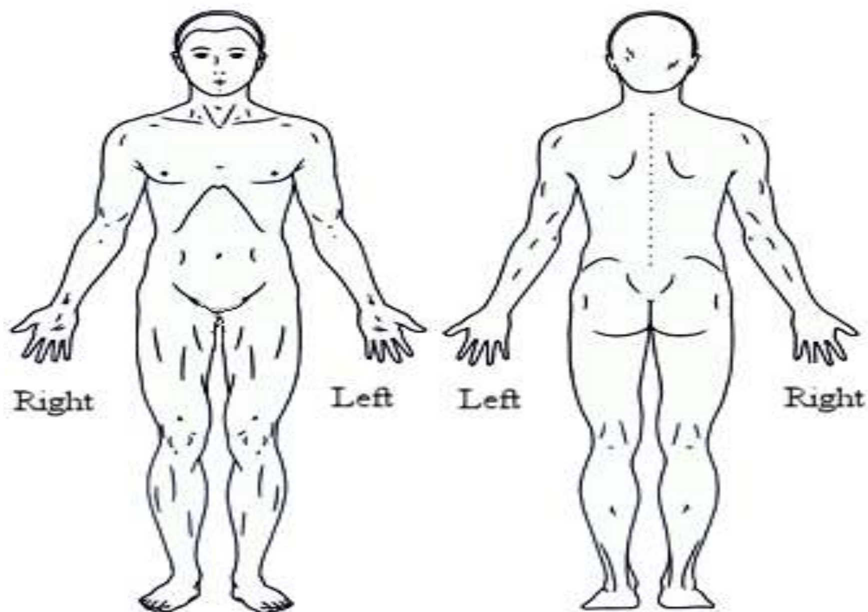
Since the accident occurred are you symptoms ❑Improving ❑Getting Worse ❑Same

Did you have any physical or illnesses Complaints BEFORE THE ACCIDENT? Yes❑ No❑ If yes, describe:

____

Have you ever been involved in an accident before? Yes❑ No❑ If yes describe dates, injuries received and what type of accident's:____

Using the symbols below, mark on the pictures where you feel pain.



Please circle your pain level, 0 means no pain and 10 means severe pain. 0 1 2 3 4 5 6 7 8 9 10

Make model and year of the you car?____

Amount of damaged to your car? ____

Make model and year of the other cars involved? ____

I authorize payment of insurance directly to Steven R Davis D.C. & Davis Chiropractic to release all information necessary to anyone to communicate with to secure the payment of benefits. I understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will immediately be due and payable. I understand that interest is charged on overdue accounts at the annual rate of 15%. California State Law requires we maintain your X-Rays. The film itself is the property of this office. Films may be loaned to another facility with authorization only.

Patient's Signature:____ Date: ______________

Guardian's Signature Authorizing Care:____ Date: ______________