

# AUTO ACCIDENT QUESTIONNAIRE

Print Name (First MI Last) \_\_\_\_\_ Date \_\_\_\_\_

## ACCIDENT INFORMATION (Please use back of this page if needed.)

Date of Accident: \_\_\_\_\_ Number of People in Your Vehicle \_\_\_\_\_ Name of Driver (if not you) \_\_\_\_\_

Were you the:  Driver  Front Passenger  Rear Passenger – Behind Driver / Middle / Behind Passenger / 2<sup>nd</sup> Row / 3<sup>rd</sup> Row

Were you wearing a seatbelt?  Yes  No

Where was your vehicle impacted?  Front  Rear  Driver side  Passenger side

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## MEDICAL INFORMATION

### At the Time of the Accident

Did you feel pain immediately after the accident?  Yes  No

If no, when?  Later that Day  Next Day  When? \_\_\_\_\_

Did you go to a hospital or see any other doctor?  Yes  No

If yes, when did you go?  Immediately  Next Day  Other

Name of hospital and/or doctor: \_\_\_\_\_

Were any x-rays taken?  Yes  No

### Since the Accident

Are your symptoms:  Getting Better  Staying the Same  Getting Worse

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## LEGAL INFORMATION

Was a police report filed?  Yes  No

Have you retained an attorney?  Yes  No

If yes, name of attorney \_\_\_\_\_ Phone \_\_\_\_\_

Your Auto Insurance Company \_\_\_\_\_ Policy # \_\_\_\_\_

Other Auto Insurance Company \_\_\_\_\_ Claim # \_\_\_\_\_

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## OFFICE POLICIES FOR PERSONAL INJURY PATIENTS

This office will accept you as a new patient based on our clinical examination and belief that chiropractic care will be effective for the treatment of your injuries. To extend you credit while you are under treatment, you must provide the appropriate financial information so that payment for services can be received. Patients must bring the following information by the third office visit or pay for their treatment.

1. Copy of police report and/or a copy of the exchange slip.
2. Name of individual and insurance company of party that is liable.
3. Copy of personal automobile policy.
4. Name and telephone number of attorney, if one has been retained.

Following the completion of your treatment in this office, your bill will be forwarded to the responsible party. Please note that this account is still your responsibility and will be subject to monthly interest charges of 1.5% effective 30 days following your initial visit.

*I have answered these questions to the best of my knowledge and certify them to be true and correct.*

Patient or Guardian Signature \_\_\_\_\_