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 / 2nd Row / 3rd 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 #** _____

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_____