

New Patient Car Accident Form

Date of Injury ___/___/___	Claim # _____
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First Name _____ MI _____ Last Name _____ Sex M ___ F ___
 Address _____ City _____ State _____ Zip _____
 Home Phone _____ Cell Phone _____ Best contact Cell Home
 Date of Birth _____ Age _____ Marital Status (Circle) M S D W
 Social Security Number _____ E-mail Address _____
 Occupation _____ Employer _____
 Work Address _____ City, _____ State _____ Zip _____
 Spouse's Name _____ # Children _____
 Drivers License No. _____ State: _____ Have you ever had Chiropractic before _____

All Charges are due when services are rendered.

Method of payment () Check () Cash () Credit Card () Care Credit

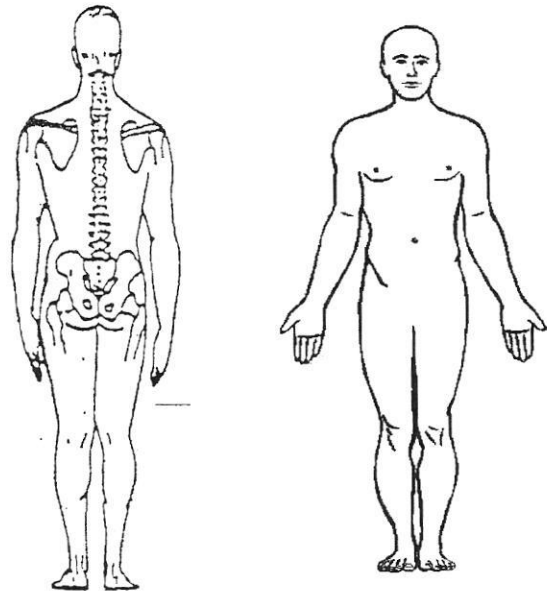
Are you or do you think that you might be pregnant? 1) Yes 2) No 3) Not Sure

Cause of complaint: (circle) 1) Auto Accident 2) Work Injury 3) Other Accident 4) Illness 5) Congenital 6) Unknown

Please Mark an X on the diagram where your problems are →

List your major complaints in order of severity

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____



I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. I authorize payment from my insurance carrier directly to this office with the understanding that all monies be credited to my account upon receipt. I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I understand that if I suspend or terminate my care and treatment, all fees for professional services rendered me will be immediately due and payable. In the event of my default, I promise to pay legal interest on the indebtedness together with such collection costs and reasonable attorney fees as may be required to effect collection.

Patient Signature _____ Date _____

Guardian or spouse's authorizing care _____

Thank You For Allowing Us To Serve You!

Vehicle Accident Report

Name _____

Date of Accident ___/___/___ Time of Accident ___:___ (AM /PM)

Were you at work when the accident occurred? _____

Have you been unable to work since injury? Yes___ No___ If yes, you were off work partially or completely

Please list date off work: _____ to _____. Are you working now? () Yes, part time () Yes, full time () No

Were you: () Driver () Passenger (Front) () Passenger (Rear) () Pedestrian

Were you wearing seatbelts? () Yes () No Was your vehicle moving? () Yes () No Other vehicle moving? () Yes () No

Type of Vehicle: () Auto () Light Truck () Truck () Van () Bus () Motorcycle () Motor Scooter () Motor-home () Bicycle

Other vehicle: () Auto () Light Truck () Truck () Van () Bus () Motorcycle () Motor Scooter () Motor-home () Bicycle

How accident occurred: () Struck by another vehicle () Struck another vehicle () Struck a stationary object () Other

Where was your vehicle hit? () Front () Rear () Rt. Side () Lft. Side () Rt. Front () Lft. Front () Rt. Rear () Lft. Rear

Where was other vehicle hit? () Front () Rear () Rt. Side () Lft. Side () Rt. Front () Lft. Front () Rt. Rear () Lft. Rear

What occurred at the moment of impact? (Circle as many as apply)

- | | | | |
|------------------------|-----------------------------|--------------------------|------------------|
| Tensed body for impact | Neck whipped forward & back | Spine torque and twisted | Thrown over seat |
| Thrown from vehicle | Pinned in vehicle | Thrown from side to side | Cut and Bruised |

Did you strike your: (Circle as many as apply)								
Head	Against the:	Dashboard	Windshield	Steering Wheel	Rt. Door	Lft. Door	Seat Frame	Unknown object
Shoulder	(Lft. /Rt.)	Dashboard	Windshield	Steering Wheel	Rt. Door	Lft. Door	Seat Frame	Unknown object
Arm	(Lft. /Rt.)	Dashboard	Windshield	Steering Wheel	Rt. Door	Lft. Door	Seat Frame	Unknown object
Upper Arm	(Lft. /Rt.)	Dashboard	Windshield	Steering Wheel	Rt. Door	Lft. Door	Seat Frame	Unknown object
Forearm	(Lft. /Rt.)	Dashboard	Windshield	Steering Wheel	Rt. Door	Lft. Door	Seat Frame	Unknown object
Elbow	(Lft. /Rt.)	Dashboard	Windshield	Steering Wheel	Rt. Door	Lft. Door	Seat Frame	Unknown object
Wrist	(Lft. /Rt.)	Dashboard	Windshield	Steering Wheel	Rt. Door	Lft. Door	Seat Frame	Unknown object
Hip	(Lft. /Rt.)	Dashboard	Windshield	Steering Wheel	Rt. Door	Lft. Door	Seat Frame	Unknown object
Knee	(Lft. /Rt.)	Dashboard	Windshield	Steering Wheel	Rt. Door	Lft. Door	Seat Frame	Unknown object
Ankle	(Lft. /Rt.)	Dashboard	Windshield	Steering Wheel	Rt. Door	Lft. Door	Seat Frame	Unknown object
Ribcage	(Lft. /Rt.)	Dashboard	Windshield	Steering Wheel	Rt. Door	Lft. Door	Seat Frame	Unknown object
Thigh	(Lft. /Rt.)	Dashboard	Windshield	Steering Wheel	Rt. Door	Lft. Door	Seat Frame	Unknown object
Shin	(Lft. /Rt.)	Dashboard	Windshield	Steering Wheel	Rt. Door	Lft. Door	Seat Frame	Unknown object
Foot	(Lft. /Rt.)	Dashboard	Windshield	Steering Wheel	Rt. Door	Lft. Door	Seat Frame	Unknown object
Low back		Dashboard	Windshield	Steering Wheel	Rt. Door	Lft. Door	Seat Frame	Unknown object
Upper back		Dashboard	Windshield	Steering Wheel	Rt. Door	Lft. Door	Seat Frame	Unknown object

Were you rendered unconscious? (Y/N) Did you receive medical attention at the scene of the accident? (Y/N)

Where did you go immediately following the accident? () Hospital () Home () Personal Doctor () To this office () Resumed activities

Continued on back