AUTOMOBILE ACCIDENT HISTORY FORM

Name:____ Date:__________________________

WERE YOU SEEN BY A MEDICAL OR CHIROPRACTIC PHYSICIAN WITHIN 14 DAYS OF YOUR CRASH? ☐ Yes ☐ No

1. Date of Accident ____________________ Time of Accident ____________________AM/PM
2. Description of Accident

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____

3. Location of Accident Street ______________________________________ City ______________________ State ____
4. Were you a: ☐ driver ☐ passenger ☐ pedestrian ☐ other ____
5. **YOUR** Vehicle Type: ☐ compact ☐ midsize ☐ truck ☐ sport utility ☐ van ☐ semi-truck
6. **OTHER** Vehicle Type(s): ☐ compact ☐ midsize ☐ truck ☐ sport utility ☐ van ☐ semi-truck
7. Who was issued the citation? ☐ nobody, we exchanged insurance info ☐ I was / my party ☐ other party
8. Type of crash? ☐ rear-ended while stopped ☐ rear-ended while moving ☐ head-on collision

   ☐ side swiped (driver / passenger) side ☐ roll over crash ☐ other ____________________________________
9. If rear-ended, did the force of the impact cause your vehicle to hit the vehicle in front of you? ☐ Yes ☐ No ☐ N/A
10. Road conditions at the time of the accident: ☐ wet ☐ dry ☐ icy ☐ other ______________________________
11. Were you wearing a seat belt? ☐ No ☐ Yes
12. Did you strike anything in the car? ☐ No ☐ Yes If yes what?______________________________________
13. If you experienced pain after the crash, please indicate where:

☐	Head	☐ Left	☐ Right	☐	Neck	☐ Left	☐ Right
☐	Upper-back	☐ Left	☐ Right	☐	Mid-back	☐ Left	☐ Right
☐	Chest	☐ Left	☐ Right	☐	Low-back	☐ Left	☐ Right
☐	Arm	☐ Left	☐ Right	☐	Elbow	☐ Left	☐ Right
☐	Knee	☐ Left	☐ Right	☐	Leg	☐ Left	☐ Right

☐ Other ____

14. Where did you go after the accident? ☐ home ☐ work ☐ hospital ☐ urgent care ☐ other ____________________

HOSPITALIZATION

15. If taken to the hospital, how did you get there? ☐ ambulance ☐ driven by friend/relative ☐ drove myself ☐ went later
16. If you went later, when did you go? ______________________ Name of hospital ________________________________
17. Were you seen in the emergency room? ☐ No ☐ Yes
18. Were you admitted to the hospital? ☐ No ☐ Yes
19. If yes, how long did you stay? ____
20. What services were performed in the emergency room or hospital? ☐ exam ☐ stitches ☐ x-rays ☐ CT or MRI

    ☐ surgery ☐ prescription(s) ______________________________________ ☐ other ____________________

Name:____ Date:__________________________

CURRENT TREATING PROVIDERS

21. When did you first consult a physician?____

(If patient consulted this office first, skip to PAST HISTORY)

22. Who did you consult? Dr. ______________________________ ☐ family physician ☐ chiropractor ☐ orthopedist
    ☐ neurologist ☐ other ____
23. What type of treatment did you receive? ☐ chiropractic manipulation ☐ injections ☐ physical therapy
    ☐ medication (type) ____ ☐ other _______________________________
24. How long were you under this provider's care? ____
25. Are you still treating with this provider? ☐ No ☐ Yes
26. Have you been treated by any other physician? ☐ No ☐ Yes
    If yes, explain: ____
27. Other important information

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PAST HISTORY

28. Have you had ANY prior accidents of any kind? ☐ No ☐ Yes (dates) ____
29. Has ANY other physician prior to this accident ever treated you for neck or back problems? ☐ No ☐ Yes
    If yes, please explain ____

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30. Have you had any prior surgeries? ☐ No ☐ Yes
    If yes, please explain ____

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31. Were you symptom free and in good health before this accident? ☐ No ☐ Yes
    If no, please explain ____

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WORK & ACTIVITIES OF DAILY LIVING

32. Have you lost any time from work since the accident? ☐ No ☐ Yes If yes, how many days? _________
33. Are you still off work? ☐ No ☐ Yes
34. Date returned ____________________________ Job description ____
35. In what way have your injuries affected your ability to work? ____

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36. Has your injury affected your activities of daily living (e.g. self-care, lift, sit, stand, sleep, sex, exercise, hobbies, etc.)?
    ☐ No ☐ Yes If yes, please explain ____

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ASSIGNMENT OF INSURANCE BENEFITS, RELEASE, & DEMAND

Insurer and Patient Please Read the Following in its Entirety

I, the undersigned patient/insured knowingly, voluntarily and intentionally assign the rights and benefits of my automobile Insurance, also known as Personal Injury Protection (P.I.P.), and Medical Payments policy of insurance to the above health care provider. I understand it is the intention of the provider to accept this assignment of benefits in lieu of demanding payment at the time services are rendered and that this document will allow the provider to file suit against an insurance company for payment of the insurance benefits. This assignment of benefits includes overdue interest payments and any potential claim for common law or statutory bad faith. If the insurer disputes the validity of this assignment of benefits then the insurer is instructed to notify the provider in writing within five (5) days of receipt of this document. Failure to inform the provider shall result in a waiver by the insurer to contest the validity of this document. The undersigned directs the insurer to pay the health care provider directly without including the patient's name on the check.

The insurer is directed by the provider and the undersigned to not issue any checks or drafts in partial settlement of a claim that contain or are accompanied by language releasing the insurer or its insured/patient from liability unless there has been a prior written settlement agreed to by the health provider and the insurer as to the amount payable under the insurance policy or contract. The provider hereby objects to any reductions or partial payments. Any partial or reduced payment, regardless of the accompanying language, issued by the insurer and deposited by the provider shall be done so under protest, at the risk of the insurer, and the deposit shall not be deemed a waiver, accord, satisfaction, discharge, settlement or agreement by the provider to accept a reduced amount as payment in full. The insurer is hereby placed on notice that this provider reserves the right to seek the full amount of the bills submitted.

If the insurer schedules a defense examination or examination under oath (herein after "EUO") the insurer is hereby INSTRUCTED to send a copy of said notification to this provider. The provider or the provider's attorney is expressly authorized to appear at any EUO or IME set by the insurer. The health care provider is not the agent of the insurer or the patient for any purpose.
This assignment applies to both past and future medical expenses and is valid even if undated. A photocopy of this assignment is to be considered as valid as the original. I agree to pay any applicable deductible, co-payments, for services rendered after the policy of insurance exhausts, and for any other services unrelated to the automobile accident. The health care provider is given the power of attorney to endorse my name on any check for services rendered by the above provider and to request any statements or examinations under oath the patient provided to any insurer.

Release of information: I hereby authorize this provider to: furnish an insurer, an insurer's intermediary, the patient's other medical providers, and the patient's attorney via mail, fax, or email, with any and all information that may be contained in the medical records; to obtain insurance coverage information in writing (declaration sheet) and telephonically from the insurer; request from any insurer all explanation of benefits (EOBs) for all providers and non-redacted PIP payout sheets; obtain any statements the patient provided to the insurer; obtain copies of all medical records, including but not limited to, documents, reports, scans, notes, bills, opinions, X-rays, IMEs, and MRIs, from any other medical provider or any insurer. The provider is permitted to produce my medical records to its attorney in connection with any pending lawsuits. The insurer is directed to keep the patient's medical records from this provider private and confidential and the insurer is not authorized to provide these medical records to anyone without the patient's and the provider's prior express written permission.

Demand: Demand is hereby made for the insurer to pay all bills within 30 days without reductions and to mail the latest non-redacted PIP payout sheet and the insurance coverage declaration sheet to the above provider within 15 days. The insurer is directed to pay the bills in the order they are received. However, if a bill from this provider and a claim from anyone else are received by the insurer on the same day the insurer is directed to not apply this provider's bill to the deductible. If a bill from this provider and claim from anyone else is received by the insurer on the same day then the insurer is directed to pay this provider first before the policy is exhausted. In the event this provider's medical bills are disputed by the insurer for any reason the undersigned hereby instructs the insurer to set aside any amount disputed (i.e., to escrow the money) and not pay the disputed amount to anyone, including myself, or any entity until the dispute is resolved. The insurer is instructed to immediately explain in writing to the above provider of any dispute.

Certification: I certify that: I have read and agree to the above; I have not been solicited or promised anything in exchange for receiving health care; I have not received any promises or guarantees from anyone as to the results that may be obtained by any treatment or service; I agree the provider's prices for medical services, treatment and supplies are reasonable and customary.

Caution: Please read before signing. If you do not completely understand this document please ask us to explain it to you. If you sign below, we will assume you understand and agree to the above.

PRINT Patient's Name: ____ Date ____________________

Patient's Signature: ____

(Signature of parent/guardian for minors)