Vehicle Accident Information/Personal Injury

Patient Information

Patient Name_____Date_____

Social Security #_____Date of Accident_____Time of Accident_____a.m./p.m.

Please describe the Accident in your own words:

_____
_____
_____

Were you the: __driver __front passenger __pedestrian __rear passenger

How many people were in the accident vehicle?_____

Insurance

Insurance company_____Claim number_____

Address_____

Attorney_____Phone number_____

Address_____

Accident Site

Road/Street Name_____Nearest Intersecting Road_____
City/State_____Driving Conditions __dry __wet __icy __other_____
Which direction were you headed?_____Speed you were traveling?_____

Vehicle

Make and model of vehicle you were in:_____
Were you wearing a seatbelt?__Yes __No What type? __Lap __Shoulder
Was the vehicle equipped with airbags? __Yes __No Did they inflate properly? __Yes __No
Did your seat have a headrest? __Yes __No What was the position of the headrest? __Low __High __Midposition

Make and model of other vehicle?_____
Which direction was the other vehicle headed?_____
Speed other vehicle was traveling?_____

Impact

Did your car impact another vehicle? __Yes __No Did your car impact a structure? __Yes __No Explain _____
Did any part of your body strike anything in the vehicle?_____
Was impact from __Front __Rear __Other_____ __Left __Right

At the time of the impact were you: __Looking straight ahead __Looking to the left __Looking to the right
__Looking up __Looking down

Were both hands on the steering wheel? __Yes __No If no, which hand was on the wheel? __Right __Left
Was your foot on the brake? __Yes __No If yes, which foot? __Right __Left

Were you: __Surprised by impact __Braced for impact

Did the police come to the accident site? __Yes __No Were there witnesses? __Yes __No
Was a police report filed? __Yes __No Was a traffic violation issued? __Yes __No If yes, to whom_____

Patient Condition

Were you unconscious immediately after the accident? __Yes __No If yes, for how long?_____
Please describe how you felt immediately after the accident?
_____
_____

Treatment

Did you go to the hospital? __Yes __No When did you go? __Immediately after the accident __Next Day __2 days or more
How did you get to the hospital? __Ambulance __Private Transportation
Name of hospital_____Name of Doctor_____
Diagnosis_____
_____
Treatment Received
_____
_____
X-rays taken_____

Symptoms/Injuries

Have you been able to work since this injury? __Yes __No How many days have you missed?_____
Prior to the injury were you able to work on an equal basis with others your age? __Yes __No
If you have had any of the following symptoms since the injury, please check:

__Arm/shoulder pain
__Back pain
__Back stiffness
__Chest pain
__Dizziness
__Ear buzzing
__Ear ringing
__Fatigue
__Feet/toe numbness
__Hand/finger numbness
__Headaches
__Irritability
__Jaw problems
__Leg pain
__Memory Loss
__Nausea
__Neck pain
__Neck stiffness
__Shortness of breath
__Sleep difficulty
__Stomach upset
__Tension
__Vision blurred

Is this condition getting progressively worse? __Yes __No __Unknown

Rate the severity of your pain on a scale of 1 (least pain) to 10 (severe pain) _____

Type of pain: __Sharp __Dull __Throbbing __Numbness __Aching __Shooting __Burning __Tingling __Cramps __ Stiffness
__Swelling __Other_____

How often do you have this pain?_____
Is it constant or does it come and go?_____

Does it interfere with your: __Work __Sleep __Daily Routine __Recreation
Activities or movements that are painful to perform: __Sitting __Standing __Walking __Bending __Lying Down

I certify that the above information is correct to the best of my knowledge.

_____ _____
Patient Signature Date

Egan Family Chiropractic
Helping Families since 1996
1078 Big Bethel Rd., Hampton, VA 23666 757-838-2500

PERSONAL INJURY/AUTO ACCIDENT
WORKERS' COMPENSATION

Authorization and Assignment
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In consideration for your undertaking to treat me, I agree to the following:

1. You authorized to release any information you deem appropriate concerning my physical condition to any insurance company, attorney or adjuster in order to process any claim for reimbursement of changes incurred for services rendered to me by you or any member of your staff.

2. **PERSONAL INJURY/AUTO MEDICAL PAYMENT-** I authorize the direct payment to Egan Family Chiropractic any sum I now owe, by my attorney out of the proceeds of any settlement to my case, and by any insurance company obligated to reimburse me for the charges made for your services.

3. **WORKERS' COMPENSATION-** Egan Family Chiropractic will file my Workers' Compensation claim with my employer after my employer's approval and authorization to treat form has been signed and returned to this office.

ULTIMATELY-

In the event that Egan Family Chiropractic is unable to collect payment from any insurance company, attorney, Workers' Compensation, or medical payment company. **I UNDERSTAND THAT I ACCEPT COMPLETE RESPONSIBILITY FOR FULL PAYMENT OF MY BILL.** If collection is necessary there will be an 18% annual interest rate added to the total due and patient will also be responsible for any fees in the collection process allowable by law.

_____ _____
Signature Date

_____
Print Name