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AUTO ACCIDENT INFORMATION FORM - IF YOU NEED MORE SPACE, WRITE ON THE BACK OF THIS PAGE

NAME _____ AGE IN YEARS _____ DATE OF BIRTH _____ SEX _____

MARITAL STATUS _____ HOME PHONE _____ WORK PHONE _____

ADDRESS _____

E-MAIL ADDRESS _____

ACCIDENT DATE _____ TIME _____ WHERE DID IT HAPPEN? _____

GIVE A DETAILED DESCRIPTION OF HOW THIS ACCIDENT/INJURY HAPPENED. _____

WHAT PARTS OF YOUR BODY WERE HURT? _____

HAVE YOU EVER HURT THESE PARTS OF YOUR BODY BEFORE? _____ IF YES, HOW AND WHEN _____

WHERE DO YOU NOW FEEL PAIN? _____

WHAT SYMPTOMS/PROBLEMS BEGAN WHEN YOU GOT HURT? _____

WHAT SYMPTOMS/PROBLEMS DO YOU FEEL RIGHT NOW? _____

HAVE YOU EVER HAD THESE SYMPTOMS/PROBLEMS BEFORE THE ACCIDENT? _____

IF YES, WHEN AND FROM WHAT? _____

WHERE WERE YOU IN THE VEHICLE? _____ WHAT TYPE OF VEHICLE WERE YOU IN? _____

WHAT WAS THE SPEED OF YOUR CAR AT IMPACT? _____ WERE YOU ACCELERATING AT IMPACT? _____

WHAT WAS YOUR VEHICLE DOING JUST BEFORE IMPACT? _____

WHAT WAS THE POINT OF IMPACT ON YOUR CAR? _____

HOW MUCH DAMAGE WAS DONE TO YOUR CAR? UNKNOWN APPROXIMATELY \$ _____

DESCRIBE THE ROAD CONDITIONS AND VISIBILITY. _____

WERE OTHER VEHICLES INVOLVED? _____ HOW MANY? _____ WAS POLICE REPORT FILED? _____

WHICH VEHICLE HIT THE OTHER? _____

DID AIRBAGS DEPLOY? _____ DID YOU LOSE CONSCIOUSNESS? _____ GET EMERGENCY CARE AT SCENE? _____

WHAT WAS THE POSITION OF YOUR HEADREST? _____

WERE YOU WEARING A SEAT BELT? _____ WHAT TYPE _____

IMMEDIATELY AFTER THE ACCIDENT WHERE DID YOU GO OR WHERE WERE YOU TAKEN? _____

WERE YOU PREPARED FOR IMPACT? _____ WAS YOUR FOOT ON THE BRAKE AT IMPACT? _____ DID THE IMPACT KNOCK

YOUR FOOT OFF THE BRAKE? _____ WHAT WAS THE POSITION OF YOUR HEAD AND NECK AT IMPACT? _____

WHAT WAS THE OTHER VEHICLE TYPE? _____ SPEED OF OTHER VEHICLE AT IMPACT _____

WHAT WAS THE OTHER VEHICLE'S POINT OF IMPACT? _____

WAS THE OTHER VEHICLE ACCELERATING AT IMPACT? _____ WHAT WAS THE OTHER VEHICLE DOING JUST BEFORE

IMPACT? _____

LIST ALL THE DOCTORS THAT YOU HAVE BEEN EXAMINED OR TREATED BY SINCE THIS ACCIDENT. INCLUDED DOCTOR'S NAME,

ADDRESS, TREATMENT YOU WERE GIVEN, REASON FOR TREATMENT, AND WHAT EFFECT DID THE TREATMENT HAD ON YOU?

DID YOU MISS WORK DUE TO THIS ACCIDENT? _____ WHAT IS THE FIRST DATE YOU MISSED _____ HAVE YOU RETURNED TO WORK _____ WHEN? _____ BETWEEN THESE DATES DID YOU DO ANY WORK? _____ IF YES, ON WHAT DATES _____ WAS ANYONE ELSE IN THE CAR WITH YOU? _____ WHO AND WHAT RELATIONSHIP DOES THAT PERSON(S) HAVE TO YOU? _____ HAS THAT PERSON(S) BEEN TREATED DUE TO THIS ACCIDENT? _____ DID YOU REPORT THIS TO YOUR AUTO INSURANCE? _____ IS THERE ANYTHING YOU CAN NOT DO AS A RESULT OF THIS ACCIDENT? PLEASE BE SPECIFIC ABOUT WHAT YOU CAN NOT DO.

To the best of my knowledge, all information above is accurate and true. I authorize my insurance carrier(s), trustees, executors, accountant, custodian &/or attorney to make payment directly to <Provider Clinic> for services rendered to me/my family by <Provider Clinic>. I agree to pay any balance left unpaid. I authorize <Provider Clinic> to send bills/claims &/or reports for services rendered directly to my insurance carrier &/or attorney and to release to my insurance carrier &/or attorney any information needed to process my claim. I acknowledge that I am completely and fully responsible for paying all fees that I or my family incur with <Provider Clinic>. If I have financial difficulties/hardships, I shall pay <Provider Clinic> according to the terms of any agreement that I make with <Provider Clinic> (which shall be made at time of initial visit). This authorization serves as a Doctor's Lien, directing my attorney to withhold from any settlement, judgment, or verdict which may be paid to my attorney or to me whatever sum is needed to protect <Provider Clinic>, and to pay <Provider Clinic> directly from those proceeds. If <Provider Clinic> has to resort to collection proceedings against me, I agree to pay all collection costs including the fees of collection agents, attorneys, and court costs, in addition to paying all fees due <Provider Clinic> for services rendered by <Provider Clinic> to &/or for me or my family. I authorize <Provider Clinic> and staff to call me on the telephone to discuss appointments, treatment information, and/or any other details related to my/my family's therapy and treatment. <Provider Clinic> and staff may leave messages about appointments on my answering machine. If I am unavailable or incapacitated, I authorize <Provider Clinic> and/or staff to discuss my case with my spouse, parents, adult children, and/or other health care providers. <Provider Clinic> is authorized to release any and all information requested to any insurance carrier, attorney or other health care provider or facility involved in my care and treatment. I further agree to pay 1 1/2%/ month interest accruing compounded on any nonoutstanding balance from the time my carrier determines that they will not pay any further bills, or on any legally required patient portion or deductible on my account.

TODAY'S DATE <Current Date> YOUR SIGNATURE _____

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