

Automobile Accident Injury Report



HEALTH, VITALITY AND COMMUNITY

Date: YY/MM/DD

Patient's Name: _____ Date of Birth: YY/MM/DD

The Accident

Date of accident: YY/MM/DD Time of accident: _____ am _____ pm

PLEASE EXPLAIN HOW THE ACCIDENT HAPPENED INCLUDING CAUSE/S AND SURROUNDING CIRCUMSTANCES:

What kind of vehicle were you in when involved in the accident? Truck Car SUV Motorcycle Other

What other vehicle was involved? Truck Car SUV Motorcycle Other _____

Were you a: Driver Passenger Pedestrian

If a passenger, please indicate your location in car: Front Seat Back-Drivers Side Back-Passenger Side

Number of passengers in your auto: _____ Were you "buckled up"? **YES NO**

Was your vehicle moving when the accident occurred? **YES NO** MPH? _____

Was the other vehicle moving when the accident occurred? **YES NO** MPH? _____

Did your vehicle hit other vehicle/s? **YES NO** Where? _____

Did other vehicle/s hit your vehicle? **YES NO** Where? _____

Impact to your vehicle was from: Behind Front Right Side Left Side



Did your seat have a headrest: **YES NO**

Were you: Surprised by the impact Braced for the impact

At the time of the impact were you looking: Straight ahead To the left Up To the right Down

Did any part of your body strike anything in the vehicle: **YES NO** Explain? _____

Were the police notified: **YES NO** Was a police report filed: **YES NO**

Were traffic citations issued: **YES NO** If yes, to whom: _____

Your Health Following The Accident:

Were you knocked unconscious: **YES NO** If yes, for how long: _____

Did your head strike the windshield or any object: **YES NO** Explain: _____

When did you feel pain: Immediately Later that day Next day Other _____

Where did you feel pain after the accident: _____

Were you taken to the emergency room? Did you require post-accident hospitalization: **YES NO**

If yes, what treatment was given: _____

Have you seen any other doctor for injuries from this accident: **YES NO** Who? _____

What was done? Their diagnosis: _____

Are you still treating with this doctor? **YES NO**

Were any of the following taken: X-Rays MRI CT Scan Other: _____

Have you had complaints in the involved area before? **YES NO** _____

Have you had similar accidents or injuries before? **YES NO** _____

Are your activities restricted as a result of the accident: **YES NO** _____

Since the accident, are your symptoms: Improving Getting Worse The Same

Present Complaints: Please check your current symptoms & rate the current severity of each on a scale of 1 - 10, with 10 being the worst.

- | | | |
|--|---|---|
| <input type="radio"/> Headache _____ | <input type="radio"/> Pins/needles in arms/legs _____ | <input type="radio"/> Anxiety _____ |
| <input type="radio"/> Head seems too heavy _____ | <input type="radio"/> Numb in fingers/arms/legs _____ | <input type="radio"/> Extreme Fatigue _____ |
| <input type="radio"/> Head/shoulders tired/heavy _____ | <input type="radio"/> Chest pain _____ | <input type="radio"/> Insomnia _____ |



- Mental dullness _____
 - Loss of memory _____
 - Equilibrium problems _____
 - Dizziness _____
 - Fainting _____
 - Tremors _____
 - Palpitation _____
 - Neck pain _____
 - Neck stiffness _____
 - Neck motion restricted _____
 - Upper back pain/stiffness _____
 - Low back pain/stiffness _____
 - Shortness of breath _____
 - Eye strain _____
 - Pain behind eyes _____
 - Eyes sensitive to light _____
 - Eyes loss of focus _____
 - Double vision _____
 - Ears buzzing/ringing _____
 - Loss of taste _____
 - Loss of smell _____
 - Sinus trouble _____
 - Extreme nervousness _____
 - Tension _____
 - Neuritis _____
 - Face Flushed _____
 - Face Pale _____
 - Excess Perspiration _____
 - Digestive Disorders _____
 - Nausea/Vomiting _____
 - Diarrhea _____
 - Constipation _____
 - Depression _____
 - Swelling _____
 - Feet/Hands Cold _____
 - Fear of Driving/Riding _____
-
- Difficulty Pain with excessive Standing Walking Riding Bending
 - Stiffness Pain upon rising in Nec Mid back Low back Other _____
 - Pain radiating into: Right arm Right leg Left arm Left leg
 - Neck Base of skull Shoulder Hips
 - Difficulty in excessive lifting Light Moderate Heavy Repetitive
 - Symptoms other than above:

Is there anything else that you would like to tell the doctor so that she may better understand you as a person or your symptoms related to the accident?



I have reported this accident to my insurance company? **YES NO**

I have an attorney representing me in this case? **YES NO** Name: _____

I will pay cash for services rendered? **YES NO** OR I request that you bill my PIP Insurance? **YES NO**

If yes, please read, sign, and complete the following "PIP INSURANCE & PATIENT PAYMENT AGREEMENT".

PIP INSURANCE & PATIENT PAYMENT AGREEMENT:

The only insurance that we file in this office is PIP for the vehicle that our patient was in.

PIP coverage is designed for medical care for those injured in a vehicle and will pay us directly for the patient's care, throughout the course of care, provided the policy holder carries PIP Coverage. We do not bill the other insurance company (even if it was their fault) because they will not pay us directly. They will only make payment to the patient when "settlement" is made with them. We do not accept attorney liens.

PIP is usually strait forward and most of the time they pay 100%. Ultimately you are responsible for 100% payment of your medical bills in this office and if the PIP denies coverage of any procedure or reduces the amount that they pay, you are responsible for that payment which is due immediately upon such notice.

You are expected to pay for your initial visit fees and any orthopedic supports or supplements that the doctor may recommend for your care and healing. When the PIP carrier pays 100% you will be reimbursed any credit due from your initial visit payment and payment for supports and supplements at the end of your case.

Please understand that it is our goal is to get you well and improve your quality of life; therefore, our type of care and records may not necessarily "build up" a case for you to sue someone. We do keep responsible daily records of your care and all diagnostic procedures including periodic re-evaluations. We do not mark up our fees for PIP insurance to make your case "look good" and the fees for PIP in this office are the same as if you were to pay us cash. If you feel you need documentation of your injuries beyond what this office offers or recommends then we suggest that you see your Medical Doctor or other specialist for those tests.

I HAVE READ, UNDERSTAND, AND FULLY AGREE TO THIS INSURANCE & PAYMENT AGREEMENT:

Today's Date: YY/MM/DD

Patient's Name: _____ Signature: _____

Witness Name: _____ Witness Signature: _____



PIP INSURANCE INFORMATION:

Patient Name: _____

Name of the insured owner of the vehicle you were in during the accident: _____

Insurance Company for the vehicle you were in: _____

Insurance Phone Number: _____

Policy Number: _____

Claim Number: _____

Claims Adjuster's name: _____

Phone Number: _____

Insurance Mailing Address where bills are to be sent:

