

### AUTO ACCIDENT DETAILS FORM

Today's Date:		Injury Date:		Time of Accident: <span style="float: right;">AM/PM</span>	
Patient Name:				DOB:	
Location of Accident:					
Describe accident in detail, including speed of vehicles:					
Were police called to the scene: Y N		Were citations issued: Y N			
Name of driver of vehicle in which you were riding:					
Were you: Driver Passenger Pedestrian Cyclist					
Road conditions: Ice Wet Rain Dark Other:					
Were you struck from: Behind Front Left Right					
Were you aware that the accident was about to occur: Y N					
Were seat/shoulder harnesses properly fastened: Y N					
Were you braking: Y N		Were you bracing for impact: Y N		Did your airbag deploy: Y N	
What was your head position prior to impact:					
What was your body position prior to impact:					
Which part of the car did your head hit:					
Were you unconscious: Y N		In shock: Y N		Dazed: Y N	
Were you hospitalized: Y N		Name of hospital:			
What were your symptoms immediately following the accident:					
Has the accident resulted in disability: Y N				Work loss: Y N	
Date that disability began: / /		Still disabled: Y N		On medication: Y N	
Check symptoms you have noticed since the accident:					
<input type="checkbox"/> Arm "falls asleep"	<input type="checkbox"/> Face flushed	<input type="checkbox"/> Memory loss			
<input type="checkbox"/> Back pain	<input type="checkbox"/> Loss of smell	<input type="checkbox"/> Neck pain			
<input type="checkbox"/> Buzzing in ears	<input type="checkbox"/> Fainting	<input type="checkbox"/> Nervousness			
<input type="checkbox"/> Chest pain	<input type="checkbox"/> Fatigue	<input type="checkbox"/> Numbness in fingers			
<input type="checkbox"/> Cold hands	<input type="checkbox"/> Feet feel cold	<input type="checkbox"/> Numbness in foot/toes			
<input type="checkbox"/> Constipation	<input type="checkbox"/> Headache	<input type="checkbox"/> Poor sleep			
<input type="checkbox"/> Depression	<input type="checkbox"/> "Heavy head"	<input type="checkbox"/> Shortness of breath			
<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Irritability	<input type="checkbox"/> Stiff neck			
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Legs/feet fall asleep	<input type="checkbox"/> Stomach upset			
<input type="checkbox"/> Ears ringing	<input type="checkbox"/> Loss of balance	<input type="checkbox"/> Tension			
<input type="checkbox"/> Eyes sensitive to light	<input type="checkbox"/> Loss of taste	<input type="checkbox"/> Shooting pain in arms			
<input type="checkbox"/> Shooting pain in legs	<input type="checkbox"/> Other	<input type="checkbox"/>			
Other, related symptoms:					
Have you seen another doctor for this accident: Y N					
Name of other doctor:					
Treatment you received:					
Response to treatment:					

**AUTO ACCIDENT INSURANCE INFORMATION**

Today's Date:	Injury Date:	Accident: Wrk Related	NonWrk Related
Patient Name:		Gender: M	F
Address:			
City:	State:	Zip:	
H Phone:	Cell:	DOB:	
Employer:			
Address:			
W Phone:	Work Status: FT PT Retired Unemployed Student		

**Adult Responsible for Minor**

You are: Parent Other	Please explain other:
Responsible person please complete following section:	
Name:	
Address:	
City:	State: Zip:
H Phone:	Cell: Birthday:
Employer:	
Address:	
W Phone:	Work Status: FT PT Retired Unemployed Student

**Patient's Insurance Company**

Insurance Co Name:	
Address:	
City:	State: Zip:
Phone:	Contact Person:
ID/Claim #:	
Open claim verified: Y N (by admin)	
Policy #:	Policy Holder Name: Group #:
Claims Adjuster Name:	
Address:	
City:	State: Zip:
Phone:	Fax:

**Medical Release of Information Authorization**

I hereby authorize the release of any medical information necessary to process this claim:

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

**Payment Authorization**

Choose one:

- Bill my insurance. I authorize payment of medical benefits to the physician or supplier for services rendered. I agree to pay deductibles and co-payment at time of service. I will be responsible to the doctor for payment of any part of my bill not covered by insurance.
- I will pay at time of service. I do not authorize insurance billing. I am responsible for payment.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_