VEHICLE ACCIDENT INFORMATION

PATIENT INFORMATION

Date_____

Patient Name_____

Date of Accident_____ Time of Accident_____ ☐ a.m. ☐ p.m.

Please describe the accident in your own words:_____

_____

_____

_____

Were you the: ☐ Driver ☐ Front Passenger ☐ Rear Passenger ☐ Pedestrian

How many people were in the accident vehicle?_____

ACCIDENT SITE

Road/Street Name_____

City/State_____

Nearest intersection with road/street_____

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

If yes, what type? ☐ Lap ☐ Shoulder

Was vehicle equipped with airbags? ☐ Yes ☐ No

If yes, did it/they inflate properly? ☐ Yes ☐ No

Did your seat have a headrest? ☐ Yes ☐ No

If yes, what was the position of the headrest?

☐ Low ☐ Midposition ☐ High

IMPACT

Did your car impact another vehicle? ☐ Yes ☐ No

Did your car impact a structure? ☐ Yes ☐ No

If yes, explain_____

_____

Did any part of your body strike anything in the vehicle?

☐ Yes ☐ No If yes, explain_____

Was impact from :

☐ Front ☐ Rear ☐ Left ☐ Right ☐ Other_____

At the time of impact were you:

☐ Looking straight ahead ☐ Looking to the right

☐ Looking to the left ☐ Looking down

☐ Looking up

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 was on the brake? ☐ Right ☐ Left

Were you: ☐ Surprised by impact ☐ Braced for impact

OTHER VEHICLE

(if applicable)

Make and model of other vehicle_____

Which direction was other vehicle headed?_____

Speed other vehicle was traveling_____

POLICE

Did the police come to the accident site? ☐ Yes ☐ No

Were there any 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 accident ☐ Next day ☐ 2 days or more after the accident

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 work days have you missed?_____

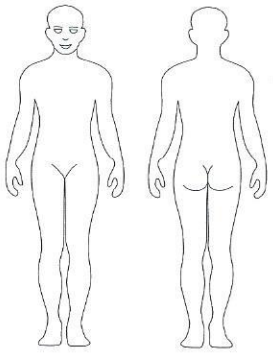
Prior to the injury were you able to work on an equal basis with others your age? ☐ Yes ☐ No

If you have had any of the following symptoms since your injury, please ☑ check:

☐ Arm/shoulder pain	☐ Feet/toe numbness	☐ Neck pain
☐ Back pain	☐ Hand/finger numbness	☐ Neck stiff
☐ Back stiffness	☐ Headaches	☐ Shortness of breath
☐ Chest pain	☐ Irritability	☐ Sleep difficulty
☐ Dizziness	☐ Jaw problems	☐ Stomach upset
☐ Ear buzzing	☐ Leg pain	☐ Tension
☐ Ear ringing	☐ Memory loss	☐ Vision blurred
☐ Fatigue	☐ Nausea	

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.



Rate the severity of your pain on a scale from 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

Movements that are painful to perform: ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____

Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient

Bradshaw Chiropractic
4331 Old Hickory Blvd. Suite C
Old Hickory, TN 37138

Authorization for Direct Payment

I hereby authorize, _____(insurance company), to make direct payment to Bradshaw Chiropractic for expense benefits allowable to me as payment toward the total charges for professional services rendered. I agree to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

Furthermore, I authorize the release of any information concerning my physical condition and treatment to any insurance company or their representatives in order to process any claim for reimbursement of charges incurred by me.

I understand that Bradshaw Chiropractic will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount to be paid directly to Bradshaw Chiropractic will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment.

If the above named insurance company does not accept assignment of benefits, insurance checks will be sent to me. I hereby agree to forward all insurance checks and explanation of benefits received by me for services rendered in this clinic directly to Bradshaw Chiropractic within 10 days of my receipt of the check. I also know that if I fail to forward the insurance checks, I will be personally liable for any and all balances due on my account. This balance, I know, will be due in full upon request by Bradshaw Chiropractic, should this situation occur.

_____ _____
Patient Name (Printed) Patient Signature

_____ _____
Date Witness Signature

Insurance Company Address:_____

_____

Name of Insured:_____

Policy Number:_____

Date of Accident:_____

Claim Number:_____

Adjuster:_____

Confidential Patient Information

Name _____ Date _____
First Middle Last Name

Home Phone _____ Cell Phone _____ Sex ____ Marital Status _____ D.O.B. _____ Age ___
Area Code/Number Area Code/Number M or F Mo/Day/Yr

Address _____ City _____ State _____ Zip _____

Social Security # _____ Occupation _____

Employer _____ Location _____ Work Phone Number _____

In Case of Emergency, Contact _____ Phone Number _____

Personal Medical History (Please check the conditions or symptoms you currently have or have had in the past)

☐ AIDS/HIV	☐ Cataracts	☐ Herniated Disk	☐ Parkinson	☐ Tuberculosis
☐ Anemia	☐ Chemical Dependency	☐ Herpes	☐ Pinched Nerve	☐ Tumors, Growths
☐ Anorexia	☐ Diabetes	☐ High Blood Pressure	☐ Pneumonia	☐ Ulcers
☐ Appendicitis	☐ Emphysema	☐ High Cholesterol	☐ Polio	☐ Varicose Veins
☐ Arthritis	☐ Epilepsy	☐ Jaw Pain/TMJ	☐ Prosthesis	☐ Whiplash
☐ Asthma	☐ Glaucoma	☐ Kidney Disease	☐ Psychiatric Care	☐ Other _____
☐ Blood Clots	☐ Goiter	☐ Liver Disease	☐ Rheumatoid Arthritis	_____
☐ Breast Lump	☐ Gout	☐ Mononucleosis	☐ Rheumatic Fever	_____
☐ Bronchitis	☐ Heart Disease	☐ Multiple Sclerosis	☐ Scarlet Fever	_____
☐ Bulimia	☐ Hepatitis	☐ Osteoporosis	☐ Stroke	_____
☐ Cancer	☐ Hernia	☐ Pacemaker	☐ Thyroid Problems	

Describe any operation you have had and the dates: _____

Are you pregnant? ☐ No ☐ Yes Have you been treated by a physician for any health condition in the last year? ☐ No ☐ Yes

Describe Condition: _____ Date of last physical exam: _____

Are you taking any medication? ☐ No ☐ Yes What kind? _____

Are you allergic to any medication? ☐ No ☐ Yes What kind? _____

Do you have insurance? ☐ No ☐ Yes Company _____

I.D. Number _____ Policy Group Number _____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. This office will file any insurance claims as a courtesy to me and will assist me in making collection from the insurance company(s). Any amount paid to this office will be credited to my account upon receipt and I shall be responsible for any unpaid amounts. I authorize direct payment to this office by my insurance company(s) and permit this office to endorse co-issued remittances for the conveyance of credit to my account. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable unless prior arrangements are made. I hereby authorize Dr. [redacted] and whomever they may designate as their assistants to administer treatment as they so deem necessary and I also authorize the release of any information acquired in the course of my examination or treatment. Fees for service in this office are payable at the time of service, unless other arrangements have been made in advance. X-rays must remain the property of this office. In the event of default by the patient, he/she agrees to pay the amount actually incurred to secure collection, including, but not limited to court costs, attorney fees set by a court, lawful fees for filing, recording or releasing in any public office any document securing an account. I certify that the above information is true and correct.

Patient's (Parent or Guardian's) Signature _____ **Date** _____