Motor Vehicle Accident

Chance Chiropractic Center
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Lafayette CO 80026
(303) 604 - 6164

Name: ____DOB___________________ Date: ____________________

Address: ____ Phone: ______________________

Please fill in all of the following to the best of your ability

Date of Accident: ____

At the time of the accident:

Were you the driver or passenger? ____________________ Sitting in the front or rear? ________________________________
If a traffic violation was issued, to whom was it issued to? ____
Number of people involved in the accident? __ Did the police come to the accident site? Y N
Was a police report filed? Y N Were you wearing your seatbelt? Y N
Did airbags deploy? Y N Was the headrest: above below the base of your skull?
Did your vehicle impact another vehicle? Y N Make and model of your vehicle ______________________________
Make and model of their vehicle ____You were going _______mph.
They were going _______ mph. Were you gripping the steering wheel? Y N
Did the impact to your vehicle come from the: Front Rear Left Right ?
Were you aware that an accident was about to take place? Y N
At impact, your head was turned: Right Left Forward

After the accident:

Please describe how you felt immediately after____
Did the accident render you unconscious? Y N How long? ____________
Did you feel tightness in the: Chest Arms Neck ? Did your neck move: Forward Backward Sideways ?
Did you feel your: Upper or Lower body move Forward Backward Sideways ?
Did any part of your body make contact with the car, where? ____
Were you bruised, where? ____
Were the paramedics called? Y N Were you taken to the Hospital? Y N
Did you go to the doctor at any time after the accident? Y N Name of Hospital?_________________________________
Did you see a Medical Doctor Orthopedist Chiropractor Dentist Other ____________________________________
Name of Doctor(s) seen____
Describe treatment received ____
Were X-rays taken ? Y N Was medication prescribed? Y N What?____
Have you been able to work since your accident? Y N
Are your work activities restricted because of this accident? Y N
Are your symptoms getting worse or better? __________
Are they constant, or do they come and go? __________
When are your symptoms the worst? AM PM Do not change with time of day
When are your symptoms the best? AM PM Do not change with time of day

Name of Insurance Company ____
Claim # ____
Claim Agent's Name ____
Address ____
Phone Number ____
Insured's Name (if different from patient)____
Date of Birth___________________ Insured's Employer ____
Do you have MedPay? _________________________What is your maximum limit? __________________________________
Have you retained an attorney? Y N Name_____________________________ Number___________________________

NOTE: Payment for all services are your responsibility. If you intend on using any form of insurance, assignment of benefits, an attorney, settlement, or other means of payment, we will assist you in filing for services rendered. **But, any outstanding balance for all services rendered, and not paid, will be your responsibility.** If the account is not paid within 90 days of the date of service, and no financial arrangements have been made, you will be responsible for legal fees, collection agent fees, and any other expenses incurred in collecting your account. Signing below acknowledges this responsibility.

I understand the above information and guarantee this form was completed to the best of my knowledge and understanding.
It is my responsibility to inform this office of any changes to the information I have provided.

Patient's (Guardian's) signature____Date_______________