

HealthCore Clinic

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AUTOMOBILE ACCIDENT

Please print

Date: _____

PATIENT INFORMATION

Patient's Name: _____

Date of Accident: _____ Time of Accident: _____ a. m. p. m.

Description of Accident: (Please be as accurate as possible, you can write on the back in needed)

Where you the: Driver Front Passenger Rear Passenger Rear Rear Passenger

ACCIDENT SITE

Street Name(s) _____

City/State _____

Driving Conditions Dry Wet Ice
 Other

YOUR VEHICLE

Make & Model _____

Direction you were headed? N E S W

Speed you were traveling? _____ Mph

Did you apply the brakes? Yes No

Were you wearing a seatbelt? Yes No

Did your airbags deploy? Yes No

Estimated Damage? \$ _____

OTHER VEHICLE(S)

Make & Model _____

Direction they were headed? N E S W

Speed they were travelling? _____ Mph

Estimated Damage? \$ _____ Unknown

IMPACT

Did your car impact another vehicle? Yes No

Did the other vehicle impact yours? Yes No

Where was your car struck? Front Rear

Side Side _____

Did you lose consciousness? Yes No

How did you feel immediately after the accident?

After the accident where did you go?

POLICE

Were the police at the scene? Yes No

Were there witnesses? Yes No

Was a police report filed? Yes No

Was a traffic citation issued? Yes No

If yes, to whom? _____

SYMPTOMS/INJURIES

- Arm-pins & Needles
- Arm/Shoulder pain
- Buzzing ear
- Chest pain
- Depression
- Dizziness
- Ears ring
- Fainting
- Fatigue
- Feet/toes numbness
- Hand/finger numbness
- Legs-pins & needles
- _____
- Light bothers your eyes
- Loss of balance
- Loss of memory
- Loss of smell
- Loss of taste
- Lower back pain
- Mid-back pain
- Neck pain
- Neck stiffness
- Shortness of breath
- Sleep difficulty
- Stomach upset
- _____

Have you lost any days of work? Yes No
 If yes, dates: _____

INSURANCE COMPANIES

Name of your insurance company _____
 Address _____
 Adjuster's Name _____
 Tel _____ Fax _____
 Your insurance claim # _____
 Does your insurance have med pay? Yes No
 Name of other insurance company _____
 Address _____
 Adjuster's Name _____
 Tel _____ Fax _____
 Other insurance claim # _____
Which insurance should claims be submitted to?

TREATMENT

Did you seek medical treatment? Yes No
 Did you go to the hospital? Yes No
 If yes, when did you go? _____
 How did you get there? Ambulance Self
 Other _____
 Name of Hospital _____
 Did you go to a doctor's office? Yes No
 Name of Doctor _____
 Diagnosis _____

 Treatment Received _____

 Were x-rays taken? Yes No
 If yes, which area? _____
 Were MRIs performed? Yes No
 If yes, which area? _____
 Were CAT scans performed? Yes No
 If yes, which area? _____
 Medication given _____

ATTORNEY

Do you have an attorney to advise you in this case?
 Yes No
 Attorney's Name _____
 Address _____

 Tel _____ Fax _____
 If you do not have an attorney, are you planning to
 hire one? Yes No

I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment in the event that my claim is denied.

 Signature

 Print Name

 Date