Accident History Questionnaire

Your Name_____ Todays Date _____

Your Auto Insurance Company_____

Claim Number_____

If applicable, Adjuster's Name _____ Adjuster's Phone Number _____

Your Health Insurance Company_____

Your Health Ins Member #_____

About Your Accident:

Date of Accident: _____ / _____ / _____

Time of Accident: _____ AM / PM State accident occurred in? _____

Driver of car? _____ Owner of car?_____

Year and model of car? _____ Model of other car? _____

Where were you seated? Driver / Front passenger / Rear passenger

Visibility at the time of the accident? Poor / Fair/ Good

Road conditions at time of accident? Icy / Rainy / Wet / Clear / Dark / Other_____

Was a ticket issued? Yes / No

If yes, to whom was it issued? _____

Number of people in your vehicle? _____

Did you see accident coming? Yes/ No Was your car breaking? Yes/No

Did you Brace for Impact? Yes/ No

Did the police come to the accident site? Yes / No Was a police report filed? Yes / No

Your seatbelt was: On / Off

The headrest was: Above / Below/ At the base of your head

Does your vehicle have airbags? Yes / No Did airbags inflate? Yes / No

Did any part of your body strike anything in the car? Yes / No

If yes, please explain:

_____

_____

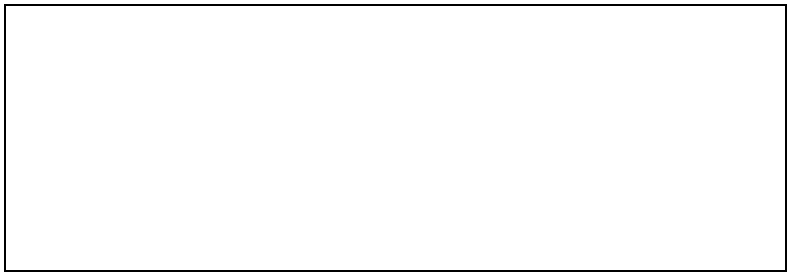
What was your approximate speed? _____

What was their approximate speed? _____

Type of accident? Head on collision/ Broad-side collision/ Rear-End collision/ Front Impact

Approximate damage to your car $ _____

Illustrate how accident happened:



After Your Accident

Where you able to get out of your car and walk unaided? Yes/ No

If no, why not?_____

Did you lose consciousness during your accident? Yes / No

If yes, how long? _____

Did you get bleeding cuts? Yes/ No

If yes, where? _____

Did you get any bruises? Yes/ No

If yes, where? _____

Could you move all parts of your body? Yes/ No

If no, what parts couldn't you move and why? _____

Describe how you felt immediately after the accident:

_____

_____

Describe how you felt later that day:

_____

_____

Describe how you felt the next day:

_____
_____

Describe how you feel now:

_____
_____

What symptoms are you experiencing as a result of this accident?

___ Dizziness ___ Difficulty sleeping ___ Jaw/TMJ problems ___ Nausea ___ Memory loss ___ Irritability ___ Arm/shoulder pain ___ Back pain ___ Headache(s) ___ Neck stiffness ___ Numb hands/fingers ___ Lower back pain ___ Blurred vision ___ Fatigue ___ Chest pain ___ Back stiffness ___ Buzzing in the ear ___ Tension ___ Short of breath ___ Leg pain ___ Ringing in the ear ___ Neck pain ___ Stomach upset ___ Numb feet/toes

Have you gone to a Hospital or seen any other Doctors? Yes / No

When did you go? Just after the accident / Next day / 2 or more days later

How did you get there? Ambulance / Private transportation

Was he/she a: MD / DO / DC / Other _____

Doctor's name? _____ Doctor's phone number?_____

What kind of treatment did you receive?

_____

Were X-rays taken? Yes/No

Was medication prescribed? Yes / No

Have you missed work? Yes/ No

If yes, from _____ to _____

Occupation? _____Employer?_____

Do you have an attorney for this claim? Yes / No

If yes, Attorney's Name _____ Attorney's Phone Number_____

UNDERSTANDING PIP BENEFITS- MOTOR VEHICLE ACCIDENTS

In Massachusetts we have no fault benefits when it comes to injuries sustained in an automobile accident. This means that YOUR auto insurance company pays for your medical bills even when the accident is the other driver's fault. Most insurance policies carry Personal Injury Protection (PIP) benefits which will cover your initial $2000 of medical expenses. This includes transportation by ambulance, emergency room assessment, diagnostic testing and doctor's visits. These charges are paid at 100% by your insurance company- with no cost to you. We will ask you for your PIP information and file your claims directly to your auto insurance carrier.

If your injuries result in the need for care exceeding $2000 you will receive a formal PIP exhaustion letter from your auto carrier. This letter will be forwarded to your health insurance carrier to let them know you were injured in a motor vehicle accident and have been receiving treatment. Your health insurance carrier will then be responsible for processing and paying your claims under the terms of your normal health insurance coverage. This may include deductibles, co payments and limitations in covered services. We will file your claims directly to your health insurance carrier.

If there is a remainder balance due after your health insurance carrier processes and pays your claim, we will forward you a bill. You will be asked to pay the bill, and we will give you a receipt. You can forward this receipt to your auto insurance carrier and they will reimburse you for any out of pocket expenses related to treatment of accident related injuries. We do not forward remainder balances back to your auto insurance carrier for coordination of benefits once PIP is exhausted.

If you sustain injuries which result in medical expenses exceeding $2000 you have the option to pursue filing a law suit against the at fault party and their insurance company. In most cases that will require the use of an attorney. With your permission, we will forward all of your office notes along with your bills to your attorney so they can have a record of your treatment and expenses. It is important to understand that treatment under a PIP claim is solely for the treatment of injuries sustained as a direct result of your accident. It is the responsibility of the auto insurance company to return you to your pre accident state of health and functioning. Once you have reached that status, as determined by Dr. Robichaud, you will be discharged from treatment under your PIP claim. You can continue to receive treatment here in the future on an as needed basis under your normal health insurance coverage.