Auto Accident Form:

Patient Name

_____

Today's Date: ____/____/_____

Please mark your involvement in the Auto Accident:

- □ Pedestrian
- □ Driver
- □ Passenger

What are your current symptoms:

- □ Pain
- □ Numbness
- □ Stiffness
- □ Weakness

Date of Accident ____/____/_____

Patient was located:

- □ Driver
- □ Passenger – Middle front
- □ Passenger – Right front
- □ Passenger – Left rear
- □ Passenger – Middle rear
- □ Passenger – Right rear

Patient Vehicle Type:

- □ Compact
- □ Mid-size
- □ Full-size
- □ SUV
- □ Pick-up
- □ Motorcycle

Second Vehicle Type:

- □ Compact
- □ Mid-size
- □ Full-size
- □ SUV
- □ Pick-up
- □ Motorcycle

Third Vehicle Type

- □ Compact
- □ Mid-size
- □ Full-size
- □ SUV
- □ Pick-up
- □ Motorcycle

Road Conditions:

- □ Clear
- □ Dark
- □ Dry
- □ Foggy
- □ Icy
- □ Wet

Road Type:

- □ Asphalt
- □ Concrete
- □ Dirt
- □ Gravel

Were you aware the accident was going to occur?

- □ Yes
- □ No

Were you wearing a seatbelt?

- □ Yes
- □ No

Did your airbag deploy?

- □ Yes
- □ No

Does your car have a head rest?

- □ Yes
- □ No

What position was the head rest in?

- □ Up
- □ Middle
- □ Down

Patient's head Position:

- □ Looking straight ahead
- □ Left Level
- □ Left up
- □ Left down
- □ Right level
- □ Right up
- □ Right Down
- □ Looking up
- □ Looking down

Accident Details:

Was your car braking?

- □ Yes
- □ No

Was your car moving?

- □ Yes
- □ No

If yes, how fast? (mph)

- □ <5
- □ 6-10
- □ 11-15
- □ 16-20
- □ 21-30
- □ 31-40
- □ 41-50
- □ 51-60
- □ 61-70
- □ >71

Was the second vehicle braking?

- □ Yes
- □ No

Was the second vehicle moving?

- □ Yes
- □ No

If yes, how fast? (mph)

- □ <5
- □ 6-10
- □ 11-15
- □ 16-20
- □ 21-30
- □ 31-40
- □ 41-50
- □ 51-60
- □ 61-70
- □ >71

Was the third vehicle braking?

- □ Yes
- □ No

Was the third vehicle moving?

- □ Yes
- □ No

If yes, how fast? (mph)

- □ <5
- □ 6-10
- □ 11-15
- □ 16-20
- □ 21-30
- □ 31-40
- □ 41-50
- □ 51-60
- □ 61-70
- □ >71

Collison Details:

First Impact:

- □ Hit by other vehicle
- □ Hit other vehicle
- □ Hit by object
- □ Hit object

Impact Location:

- □ Front
- □ Front-right
- □ Front-left
- □ Left
- □ Right
- □ Right-rear
- □ Left-rear
- □ Rear
- □ Top

Second Impact:

- □ Hit by other vehicle
- □ Hit other vehicle
- □ Hit by object
- □ Hit object

Impact Location:

- □ Front
- □ Front-right
- □ Front-left
- □ Left
- □ Right
- □ Right-rear
- □ Left-rear
- □ Rear
- □ Top

Collision Results:

Body was thrown:

- □ Forward
- □ Backward
- □ Left
- □ Right
- □ Can't Remember

Head Hit:

- □ Airbag
- □ Front windshield
- □ Rearview mirror
- □ Steering wheel
- □ Dashboard
- □ Back of the front seat
- □ Side window/door
- □ Another person's body
- □ Headrest

Chest Hit:

- □ Airbag
- □ Steering wheel
- □ Dashboard
- □ Back of the front seat
- □ Side window/door
- □ Another person's body

Shoulders Hit:

- □ Shoulder harness
- □ Side window/door
- □ Back of front seat
- □ Another person's body

Knees Hit:

- □ Steering wheel
- □ Dashboard
- □ Back of the front seat
- □ Door panel
- □ Center console
- □ Another person's body

Hips Hit:

- □ Steering wheel
- □ Dashboard
- □ Back of front seat
- □ Door panel
- □ Center console
- □ Another person's body

Vehicle Damage:

Patient Vehicle:

- □ Totaled
- □ Significant damage
- □ Light damage
- □ No damage

Second Vehicle:

- □ Totaled
- □ Significant damage
- □ Light damage
- □ No damage

Third Vehicle:

- □ Totaled
- □ Significant damage
- □ Light damage
- □ No damage

Hospitalized:

Were you hospitalized?

- □ Yes
- □ No

When were you hospitalized?

- □ Immediately
- □ Later same day
- □ Next day
- □ Date:_____ _____

How were you transported to the hospital?

- □ Ambulance
- □ Life flight
- □ Private transportation

What did the hospital recommend?

- □ No instructions
- □ See this clinic
- □ See DC
- □ See own doctor
- □ See orthopedist
- □ See neurologist
- □ Prescription medication
- □ Other: _____ _____ _____

Did you have any x-rays taken?

- □ Yes
- □ No

If yes, what areas?

_____ _____

King George Family Chiropractic

Auto Accident Information:

Name of insurance company responsible:

_____

Date of accident:

_____

Address:

_____

Phone number:

_____

Contact person:

_____

Claim Number:

_____

Lawyer Information:

Lawyer Office:

_____

Address:

_____

Phone number:

_____

Contact person:

_____

Signature: _____

Date: _____

Patient's Name: _____ File Number: _____

King George Family Chiropractic

9305 Kings Highway, Suite A

King George, VA 22485

Medical Report and Doctor's Lien

I do hereby authorize King George Family Chiropractic and its agents to furnish you, my attorney, with a full report of his examination, diagnosis, treatment, prognosis, etc., of myself in regard to the accident in which I was recently involved.

I hereby authorize and direct you, my attorney, to pay directly to said office such sum and may be due and owing for medical services rendered me by both reason of this accident and by reason of any other bills that are due the office and to withhold such sums for any settlement, judgement or verdict as may be necessary to adequately protect said office. And I hereby further give a Lien on my case to said office against any and all proceeds of my settlement, judgement or verdict, which may be paid to you, my attorney, or myself, as the result of the injuries for which I have been treated or injuries in connection therewith.

I agree never to rescind this document and that a recession will not be honored by my attorney. I hereby instruct that in the event another attorney is substituted in this matter, the new attorneys honor this lien as inherent to the settlement and enforceable upon the case as if it were executed by them.

I fully understand that I am directly and fully responsible to said office for all medical bills submitted for service rendered me and that this agreement is made solely for the doctors

additional protection and in consideration of awaiting payment. And I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee.

Please acknowledge this letter by signing below and returning to the doctors office. I have been advised that if my attorney doesn't wish to cooperate in protecting the doctors interest, the doctor will not await payment but will require me to pay payments on a current basis.

_____ _____

Patients Signature Date

The undersigned being attorney of record for the above patient does hereby agree to observe all the terms to the above and agrees to withhold such sums from any settlement, judgement, or verdict, as may be necessary to adequate protect said office above- named.

_____ _____

Attorney's Name Date

Please sign and date. Return one copy to the doctor's office. Keep a copy for your records.