VEHICLE ACCIDENT INFORMATION

First Name:_____ Middle Initial: _____ Last Name: _____ Sex: M / F

Date of Accident:_____ Time of Accident _____ am / pm

Insurance Carrier:_____ Phone:_____ Claim #:_____

Carrier Address:_____ Adjuster's Name:_____

Attorney Name:_____ Law Office: _____ Phone: _____

Describe the Accident:_____

_____

_____

Were You the: O Driver O Front Passenger O Rear Passenger O Pedestrian

ACCIDENT SITE

Street Name:_____ City/State:_____ Direction Headed:_____
Driving Conditions: O Dry O Wet O Icy O Poor Visibility Speed You Were Traveling: _____mph

VEHICLE INFORMATION

Make and Model of Vehicle You Were In: _____ Were You Seat Belted: Y / N
Was Vehicle Equipped With Airbags? Y / N Did the Airbag Inflate Properly? Y / N
Did You Impact Another Vehicle? Y / N Make and Model of Other Vehicle: _____

Direction Headed: _____ Speed Other Vehicle was Traveling: _____mph

IMPACT INFORMATION

Did Your Vehicle Impact Another Structure? Y / N (Describe)_____
Your Vehicle Was Hit In the: O Rear O Front O Left O Right Did You See it Coming? Y / N
Type of Accident: O Rear End Collision O Head On O Broad Side O Hit & Run O Multiple Cars
Other: (Describe)_____
Did Any Part of Your Body Strike Anything in the Vehicle? Y / N Did You Lose Consciousness? Y / N
Describe What Happened To You Upon Impact: _____
Did You Go To The Hospital? Y / N When? O Immediately O Next Day O Two or More Days Later
Did You Go By Ambulance? Y / N Name of the Hospital _____
Diagnosis: _____ Treatment_____
Name of Doctor: _____ X-Rays / Imaging? Y / N Body Part? _____
Did You Have Any: O Cuts O Scrapes O Bleeding O Bruises O Fractures O Dislocations
Have You Been Able To Work Since This Injury? Y / N How Many Missed Days? _____
What Is Your Occupation? _____
Describe Your Work Activities: (heavy lifting / bending / standing etc...)_____

_____

Are You Currently Able To Perform Your Daily Work Activities Without Pain? Y / N
Does This Condition Interfere With Your: O Work O Sleep O Daily Routing O Recreation O Other
Explain: _____
Did You Have Any Other Physical Complaints Before The Accident? Y / N (Explain)_____

_____

I certify that the above information is correct to the best of my knowledge. I authorize my insurance benefits to be paid directly to Kent Island Chiropractic & Rehabilitation. I understand that I am financially responsible for any balance. I authorize release of all information necessary to process my claim with my insurance company.

Patient / Guardian Signature: _____ Date: _____