Active Family & Sports Chiropractic PLLC

Automobile Accident Questionnaire

Name:_____Date:_____

Do you have an attorney handling this case? ☐ yes ☐ no If yes, who? (name/address)_____

Insurance Information
Patient's automobile insurance: _____

Insured's name (if other than patient) _____

Policy #: _____Claim #: _____

Insurance Company Name: _____Adjuster's name/phone:_____

Phone#: _____Address: _____City: _____State/Zip:_____

Other party's insurance: _____

Insured's name (if other than patient) _____

Policy #: _____Claim #: _____

Insurance Company Name: _____Adjuster's name/phone:_____

Phone#: _____Address: _____City: _____State/Zip:_____

Accident Details

1. Date of Accident: _____Time:_____ a.m./p.m.

2. Driver of car: _____Where you were seated:_____

3. Owner of car: _____Year and Model of car:_____

4. Visibility at time of accident: poor / fair / good / other: _____

5. Road conditions at time of accident: icy / rainy / wet / clear / dark / other: _____

6. Where was your car struck? Right / left / rear / front / side / other: _____

7. Type of accident: ☐ head-on collision ☐ broad-side collision ☐ rear-end collision ☐ front impact, rear-ended car in front ☐ non-collision: _____

8. What part of the car was damaged? _____

9. Describe what happened to you upon impact? _____

10. Did you see the accident was about to happen? ☐ Yes ☐ No 11. Did you brace for impact? ☐ Yes ☐ No

12. Were you wearing a seatbelt? ☐ Yes ☐ No 13. Were you wearing a shoulder harness? ☐ Yes ☐ No

14. Does the car have headrests? ☐ Yes ☐ No 15. If yes, what was the position of your headrest?
☐ top of headrest even with bottom of head ☐ top of headrest even with top of head ☐ top of headrest even with middle of head

16. Was your car braking? ☐ Yes ☐ No Was the other car braking? ☐ Yes ☐ No

17. Was your car moving at the time of the accident? ☐ Yes ☐ No If yes, how fast would you estimate? _____

18. How fast would you estimate the other car was traveling? _____

19. What was the position of your head and body at the time of impact? ☐ head turned left/right ☐ body straight in sitting position ☐ head looking back ☐ body rotated left/right ☐ head straight forward ☐ other:_____

20. At the time of the accident, recall what parts of your head or body hit what parts of the vehicle:

_____

_____

21. As a result of the accident were you: ☐ rendered unconscious ☐ dazed ☐ other: _____

22. Could you move all parts of your body? ☐ yes ☐ no If no, why not?_____

23. Were you able to get out of the car and walk unaided? ☐ yes ☐ no If no, why not? _____

24. Did you have any cuts or bruises from this accident? ☐ yes ☐ no If so, where? _____

25. Describe how you felt immediately after the accident? _____

How did you feel later that ☐ day ☐ night? _____

How did you feel the next day(s)? _____

26. Check symptoms apparent <u>since</u> the accident:

☐ headache	☐ loss of smell	☐ numbness in fingers	☐ neck pain/stiffness
☐ loss of taste	☐ cold hands	☐ mid-back pain	☐ loss of memory
☐ cold feet	☐ low-back pain	☐ fatigue	☐ diarrhea
☐ tension	☐ constipation	☐ pain behind eyes	☐ shortness of breath
☐ chest pain	☐ dizziness	☐ irritability	☐ nervousness
☐ fainting	☐ depression	☐ cold sweats	☐ anxious
☐ sleeping problems	☐ loss of balance	☐ numbness in toes	

☐ ringing/buzzing in ears ☐ eyes sensitive to light ☐ other:_____

27. Have you missed time from work? ☐ yes ☐ no Work hours are: ☐ full-time ☐ part-time

If you have missed time from work, how much time have you missed? _____

28. Did the accident occur during your work hours? ☐ yes ☐ no

29. Did you seek medical help immediately/soon after the accident? ☐ yes ☐ no

If yes, how did you get there? _____

30. Doctor/hospital/clinic seen: _____ Date: _____

31. What was done at hospital/clinic? _____

Were x-rays taken? ☐ yes ☐ no If yes, of what body part? _____

32. What treatments/prescriptions were given? ☐ bed rest ☐ brace ☐ adjustments ☐ medications

33. What benefit(s) did you receive from treatment(s)? _____

34. Date of last treatment: _____

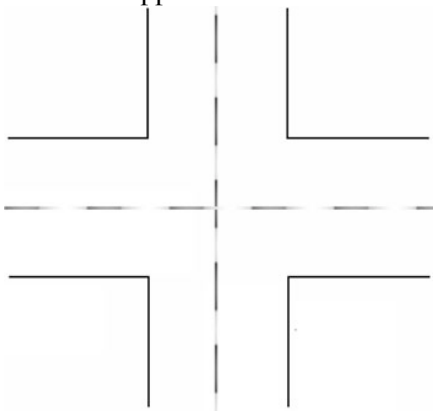
35. Are any of your activities of daily living any different now compared to before the accident? ☐ yes ☐ no

List anything you are unable to do: _____

List anything that is painful to do: _____

List anything that is difficult to do: _____

36. Indicate on the diagram below how the accident happened:



Comments: _____
_____
_____

Assignment of Payment

My attorney and/or insurance carrier are hereby requested and authorized to pay direct to Active Family & Sports Chiropractic PLLC any monies due on account, the same to be deducted from any settlement made on my behalf. Further, I agree to pay Active Family & Sports Chiropractic PLLC the difference, if any between the total amount of charges on my account and the amount paid by the attorney and/or insurance carrier. It is further understood that I, the undersigned agree to pay Active Family & Sports Chiropractic PLLC the full amount of charges on my account should my condition be such that it is not covered by my policy or if for any reason the insurance carrier refuses to pay my claim.

Patient's signature: _____Date:_____

Printed name: _____

Witness:_____

Active Family & Sports Chiropractic PLLC

1260 Gallaher Road, Suites B & C - Kingston, TN 37763
Office (865) 248-8167
Fax (865) 248-8215
www.activefamilytn.com
activefamilytn@gmail.com

To: Adjustor / Attorney

_____

_____

_____

I do hereby authorize the above doctor to furnish you, my attorney/adjustor, with a full report of his examination, diagnosis, treatment, prognosis, etc., of myself in regards to the accident in which I was involved.

I hereby authorize and direct you, my attorney / adjustor to pay directly to said doctor such sums as may be due and owing him for medical services rendered me both by reason of this accident and by reason of any other bills that are due his office and to withhold such sums from my settlement, judgment, or verdict as may be necessary to adequately protect said doctor, and I hereby further give lien on my case to said attorney or myself as the result of the injuries for which I have been treated of injuries in connection therewith. The consideration for this lien is the forbearance of Active Family & Sports Chiropractic PLLC not attempting to collect or filing suit against the patient for a period of six (6) months after treatment has ended for this accident and for treating the patient without being paid until after treatment has ended. My account is subject to a late charge of 1.5% per month (18% per annum) on all past due invoices. Furthermore, I understand that any collection fees (including attorney fees) incurred by Active Family & Sports Chiropractic PLLC, Which the parties hereby fix at 33½% of any balance due plus court costs, will be borne by my account. I assume personal and individual responsibility and liability, and guarantee payment of all charges due and payable to Active Family & Sports Chiropractic PLLC.

I fully understand that I am directly and fully responsible to said doctor for all medical bills submitted by him for services rendered me and that this agreement is made solely for said doctors for all medical bills submitted by him for services rendered me and that this agreement is made solely for said doctors additional protection and in consideration of his awaiting payment. And I further understand that such payment is not contingent on any settlement, judgment, or verdict, which I may eventually recover said fee.

Patient's Signature: _____ Dated: _____

The undersigned being attorney / adjustor of records for the above patient does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgment, or verdict as may be necessary adequately protect said doctor above named

Attorney's Signature: _____ Dated: _____

Medical Records Release

Patient's name _____

Date of birth ____/____/____

Social Security Number _____-___-_____

Address _____
_____
_____
_____

Telephone number (____) ____-_____

Please release my medical records from:

FROM: _____
_____
_____
_____
_____
_____

TO: Active Family & Sports Chiropractic, PLLC
1260 Gallaher Rd. Ste. B & C
Kingston, TN 37763
Phone (865) 248-8167
Fax (865) 248-8215
Dr. Jude Miller DC, MS
Dr. Holly A. Tucker DC, FASA

Please release all records, including but not limited to, progress notes, operative notes, laboratory test results, diagnostic tests, and x-rays. Unless otherwise specified.

I HEREBY AUTHORIZE THE RELEASE OF MY MEDICAL RECORDS AS PROVIDED ABOVE.

_____ _____
Patient's Signature Date

_____
Print Patients Name