Automobile Accident Questionnaire

Accident Information

Name:_____ Date:_____

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 you were going? _____

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? _____

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: _____

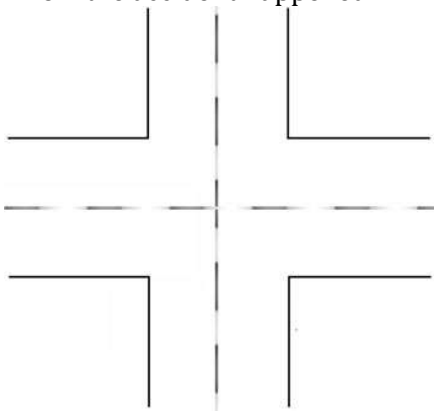
35. Are any of your activities of daily living any different now compared to before the accident?
□ yes □ no

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: _____

_____

37. Do you have an attorney handling this case? □ yes □ no

If yes, who? (name/address)

Insurance Information

Patient's personal insurance:

Insured's name (if other than patient)

Policy #:

Insurance Company Name:

Phone#:

Address: City: State/Zip:

Claim #: Adjuster's name/phone:

Other party's insurance:

Insured's name (if other than patient) Policy #:

Insurance Company Name: Phone#:

Address: City: State/Zip:

Claim #: Adjuster's name/phone:

Other insurance:

Insured's name (if other than patient) Policy #:

Insurance Company Name:

Phone#:

Address: City: State/Zip:

Claim #: _____

Adjuster's name/phone: _____

Patient's Demographic Information
Patient's full name: Social Security #: _____

Address: _____

Date of Birth: _____

Mailing address (if different): _____

Phone: _____

Employer name: _____

Spouse's Occupation: _____

Employer's address: _____

Work phone: _____

Spouse's name: _____

Spouse's Social Security #: _____

Spouse's employer: _____

Occupation: _____

Assignment of Payment

My attorney and/or insurance carrier are hereby requested and authorized to pay direct to **[enter clinic name]** any monies due on account, the same to be deducted from any settlement made on my behalf. Further, I agree to pay **[enter clinic name]** 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 **[enter clinic name]** 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: _____

IRREVOCABLE ASSIGNMENT OF HEALTH-CARE INSURANCE RECEIVABLES
UNDER ARTICLE 9 – SECURED TRANSACTIONS –
UNIFORM COMMERCIAL CODE (SDCL CHAPTER 57A-9) and
AUTHORIZATION TO RELEASE HEALTH-CARE INFORMATION

Dr. James Schwietert
Schwietert Chiropractic Clinic
814 Columbus St
Rapid City, SD 57701
605.342.0748

TO: _____
(name of insurance company/attorney)

I, the undersigned, do hereby irrevocably assign, set over and grant a perfected security interest pursuant to the provisions of SDCL 57A-9 to Schwietert Chiropractic Clinic, PC in and to any and all health-care insurance receivables due the undersigned as a result of health-care services provided me by the above named doctor or clinic by reason of accident, illness or any other health related condition. This is an irrevocable assignment of my rights and benefits to any monies owed or received for my benefit in the amount equal to any outstanding balance owed by me to the above named doctor or clinic.

In the event my insurance company or any other party obligated to make payments to me refuses to make payment upon demand by me or the above named doctor or clinic, I hereby assign and transfer to said doctor or clinic any and all causes of action I may have now or in the future against said party and do hereby authorize said doctor or clinic to prosecute said cause of action in my name or the name of said doctor or clinic and to compromise, settle or otherwise resolve such claim or cause of action.

I understand that I remain personally liable for all amounts due said doctor or clinic and that this Assignment and Authorization does not constitute consideration for said doctor or clinic to await payment and that the same may demand payment immediately upon rendering service and may charge interest at 15% per annum (compounded daily) on all balances after 30 days. If said doctor or clinic must take any collection action, I will be liable for all costs of collections actions, including court costs and reasonable attorney fees.

I authorize the above named doctor or clinic to release any records or information regarding my treatment to any insurance company, third party payor or attorney to facilitate collection of all benefits due me under this Assignment and Authorization and further authorize them to endorse on my behalf all checks and drafts issued to me, in my name or for my benefit.

This Assignment and Authorization shall be binding upon my legal heirs, personal representative(s), successors and assigns and any other person legally acting on my behalf.

Patient's Signature _____ SS#_____-____-_____ Date:_____

Signature of Parent, Spouse or Guardian Authorizing Care_____

Date: _____