Automobile Accident Paperwork

It is important that each section of our Auto Accident forms are fully completed. All the information provided here is used to generate an insurance report that is required to be sent to your Insurance company. Any questions that are not answered will result in a delay of your information and invoices being sent to your insurance company for reimbursement.

Personal Information:

First name: _____ Last name: _____

Address: _____

City: _____ State: _____ Zip: _____

e-mail: _____

Home phone: _____ Cell phone: _____

Date of Birth: _____ Dominant hand: Right ☐ Left ☐

Date of Injury: _____

Please describe accident in detail:

_____

_____

_____

_____

_____

Accident Details: Please answer the questions below. This section pertains to you and the accident. If a question is not applicable, please write NA.

Your Vehicle Type:
○Car ○S.U.V. ○Van ○Bus
○Large Truck ○Pickup'Truck

Your Position in Vehicle
○Driver ○Front Passenger
○ L.Rear Passenger ○ R.Rear Passenger

Other Position:_____

Year, make and model of vehicle:

_____

Time/Speed/Damage
Time of Accident: Your Speed ☐
Their Speed ☐

Damage to your vehicle:
○Mild ○Moderate ○Totaled

What was your vehicle doing at time of accident?
○ Stopped at intersection ○ Stopped in traffic ○ Stopped at a light
○ Making a right turn ○ Making a left turn ○ Parking
○ Proceeding along ○ Slowing down ○ Accelerating

Other:_____

Details of Accident:

Visibility at the time:
○ Good ○ Fair ○ Poor

Road Conditions at Time of Accident:
○ Icy ○ Wet ○ Sandy
○ Dark ○ Clean & Dry

Point of Impact:
○ Head-On ○ Rear-End
○ Left front ○ Right front
○ Left rear ○ Right rear

Other:_____

Who hit who/what:
○ You hit other vehicle
○ Other vehicle hit you
You hit....(Type in object below)

Other:_____

Additional Accident Information:

During the Accident:

Body Position, etc.
Did you see the accident coming?..... Yes ☐☐ No
Were you braced for the impact?.....Yes ☐☐ No
Did you have a seat belt on?..... Yes ☐☐ No
Did you have a shoulder harness on? Yes ☐☐ No
Did the driver's front air bag deploy?.. Yes ☐☐ No
Did passenger front air bags deploy? Yes ☐☐ No
Did the side air bags deploy?..... Yes ☐☐ No
Does your vehicle have headrests?... Yes ☐☐ No

Headrest Position?
○ Even with top of head
○ Even with bottom of head
○ Even with middle of the neck

What was the direction of the head at the time of impact?
○ Facing straight forward ○ Turned to the right ○ Turned to the left

Did your body strike the inside of your vehicle?.....Yes ☐☐ No
If Yes, describe:

Did you lose consciousness during the injury?.....Yes ☐☐ No
If Yes, for how long?

Your vehicle's Estimated Damage:

Damage to their vehicle:
○ Mild ○ Moderate ○ Totaled

Did police show up at the scene? Yes ☐☐ No

Was an accident report filled out? Yes ☐☐ No

If Yes, name of Police department:

_____

Emergency Room?
Where did you go after the accident?
○ Home ○ Work
○ Hospital ER ○ Private doctor

How did you get there?
○ Drove Self ○ Ambulance
○ Somebody Else ○ Police

Name of Hospital / Urgent care / Private doctor:

_____

X-rays done? Yes ☐☐ No **Was lab work done?** Yes ☐☐ No

Body parts X-rayed? What lab work?

The x-rays revealed..

Treatments: ☐ Cervical Collar ☐ Ice Other

Medications:

Follow-up Instructions:

After the Accident:
Check off the symptoms right after and a few days following the accident.

☐ Headache ☐ Loss of smell ☐ Tension ☐ Loss of taste ☐ Diarrhea
☐ Neck pain ☐ Dizziness ☐ Irritability ☐ Toe numbness ☐ Depression
☐ Neck stiffness ☐ Nausea ☐ Mid back pain ☐ Constipation ☐ Anxious
☐ Fainting ☐ Confusion ☐ Low back pain ☐ Cold hands ☐ Chest pain
☐ Ringing in ears ☐ Fatigue ☐ Nervousness ☐ Cold Feet
☐ Pain behind eyes ☐ Shortness of breath ☐ Sleeping problems

Others:

Description of Symptoms: Please describe your symptoms in the boxes below. Describe **ONE** area of concern per section. Example - if your back, neck and shoulders were all impacted by the accident, describe each location **INDIVIDUALLY**.

Please choose which side of the body was affected.

L = Left
R = Right
B = Both sides

1st area of concern

Location of Pain:

- ❑ Headaches LO RO BO
  - ○ Front of Head
  - ○ Top and/or Sides
  - ○ Back of Head
- ❑ Jaw..... LO RO BO
- ❑ Eye..... LO RO BO
- ❑ Neck..... LO RO BO
- ❑ Uppr. Back.. LO RO BO
- ❑ Mid Back.... LO RO BO
- ❑ Low Back.... LO RO BO
- ❑ Chest..... LO RO BO
- ❑ Abdomen.... LO RO BO
- ❑ Ribs..... LO RO BO
- ❑ Buttocks.... LO RO BO
- ❑ Shoulder..... LO RO BO
- ❑ Uppr. Arm... LO RO BO
- ❑ Foreman..... LO RO BO
- ❑ Hand..... LO RO BO
- ❑ Hip..... LO RO BO
- ❑ Leg..... LO RO BO
- ❑ Foot..... LO RO BO

Other Locations:

Types of Pain:

❑Dull ❑Numbing
❑Throbbing ❑Shooting
❑Spasm ❑Cutting
❑Sharp ❑Tingling
❑Burning ❑Pounding
❑Stinging ❑Cramping
❑Aching ❑Constricting

Other Types of Pain:

Does this Pain Radiate?

- ❑ Head.....LO RO BO
- ❑ Neck..... LO RO BO
- ❑ Shoulder...LO RO BO
- ❑ Arm.....LO RO BO
- ❑ Hand..... LO RO BO
- ❑ Hip..... LO RO BO
- ❑ Leg..... LO RO BO
- ❑ Foot..... LO RO BO

Other Locations:

Actions Affecting Pain

B=Brings on A=Aggravates R=Relieves

	B	A	R
❑ In the A.M.	❑	❑	❑
❑ In the P.M.	❑	❑	❑
❑ Bending Fwd	❑	❑	❑
❑ Bending Back	❑	❑	❑
❑ Bending Left	❑	❑	❑
❑ Bending Rt.	❑	❑	❑
❑ Twisting Left	❑	❑	❑
❑ Twisting Rt.	❑	❑	❑
❑ Coughing	❑	❑	❑
❑ Sneezing	❑	❑	❑
❑ Straining	❑	❑	❑
❑ Standing	❑	❑	❑
❑ Sitting	❑	❑	❑
❑ Lifting	❑	❑	❑
Other Actions:			
	❑	❑	❑
	❑	❑	❑
	❑	❑	❑
	❑	❑	❑

Pain Frequency:

- ○ Up to 1/4 of awake time
- ○ 1/4 to 1/2 of awake time
- ○ 1/2 to 3/4 of awake time
- ○ Most all the time

Pain Intensity:

- ○ Doesn't affect daily activities
- ○ Somewhat affects activities
- ○ Seriously affects activities
- ○ Prevents activities

2nd area of concern

Location of Pain:

- ❑ Headaches LO RO BO
  - ○ Front of Head
  - ○ Top and/or Sides
  - ○ Back of Head
- ❑ Jaw..... LO RO BO
- ❑ Eye..... LO RO BO
- ❑ Neck..... LO RO BO
- ❑ Uppr. Back.. LO RO BO
- ❑ Mid Back.... LO RO BO
- ❑ Low Back.... LO RO BO
- ❑ Chest..... LO RO BO
- ❑ Abdomen.... LO RO BO
- ❑ Ribs..... LO RO BO
- ❑ Buttocks.... LO RO BO
- ❑ Shoulder..... LO RO BO
- ❑ Uppr. Arm... LO RO BO
- ❑ Foreman..... LO RO BO
- ❑ Hand..... LO RO BO
- ❑ Hip..... LO RO BO
- ❑ Leg..... LO RO BO
- ❑ Foot..... LO RO BO

Other Locations:

Types of Pain:

❑Dull ❑Numbing
❑Throbbing ❑Shooting
❑Spasm ❑Cutting
❑Sharp ❑Tingling
❑Burning ❑Pounding
❑Stinging ❑Cramping
❑Aching ❑Constricting

Other Types of Pain:

Does this Pain Radiate?

- ❑ Head.....LO RO BO
- ❑ Neck..... LO RO BO
- ❑ Shoulder...LO RO BO
- ❑ Arm.....LO RO BO
- ❑ Hand..... LO RO BO
- ❑ Hip..... LO RO BO
- ❑ Leg..... LO RO BO
- ❑ Foot..... LO RO BO

Other Locations:

Actions Affecting Pain

B=Brings on A=Aggravates R=Relieves

	B	A	R
❑ In the A.M.	❑	❑	❑
❑ In the P.M.	❑	❑	❑
❑ Bending Fwd	❑	❑	❑
❑ Bending Back	❑	❑	❑
❑ Bending Left	❑	❑	❑
❑ Bending Rt.	❑	❑	❑
❑ Twisting Left	❑	❑	❑
❑ Twisting Rt.	❑	❑	❑
❑ Coughing	❑	❑	❑
❑ Sneezing	❑	❑	❑
❑ Straining	❑	❑	❑
❑ Standing	❑	❑	❑
❑ Sitting	❑	❑	❑
❑ Lifting	❑	❑	❑
Other Actions:			
	❑	❑	❑
	❑	❑	❑
	❑	❑	❑
	❑	❑	❑

Pain Frequency:

- ○ Up to 1/4 of awake time
- ○ 1/4 to 1/2 of awake time
- ○ 1/2 to 3/4 of awake time
- ○ Most all the time

Pain Intensity:

- ○ Doesn't affect daily activities
- ○ Somewhat affects activities
- ○ Seriously affects activities
- ○ Prevents activities

Activities of Daily Living: Using the following 1-5 scale, choose the number that describes the difficulties listed below.

1 = I can do it without any difficulty
2 = I can do it without much difficulty, despite SOME pain
3 = I manage to do it by myself, despite MARKED pain
4 = I manage to do it despite the pain, but only if I have help
5 = I cannot do it at all, because of the pain

Self care Personal Hygiene	1	2	3	4	5
Bathing					
Drying hair					
Brushing teeth					
Putting on shoes					
Preparing meals					
Taking out the trash					
Showering					
Combing hair					
Making the bed					
Tying shoes					
Eating					
Doing laundry					
Washing hair					
Washing face					
Putting on a shirt					
Putting on pants					
Cleaning dishes					
Going to the toilet					

Physical Activities	1	2	3	4	5
Standing					
Walking					
Kneeling					
Bending back					
Twisting left					
Leaning back					
Sitting					
Stooping					
Reaching					
Bending left					
Twisting right					
Leaning left					
Recling					
Squatting					
Bending forward					
Bending right					
Leaning forward					
Leaning right					
Standing for long periods					
Sitting for long periods					
Walking for long periods					
Kneeling for long periods					

Functional Activities	1	2	3	4	5
Carrying small objects					
Lifting weights off the floor					
Pushing things while seated					
Exercising upper body					
Carrying large objects					
Lifting weights off table					
Pushing things while standing					
Exercising lower body					
Carrying brief case					
Climbing stairs					
Pulling things while seated					
Exercising arms					
Carrying large purse					
Climbing inclines					
Pulling things while standing					
Exercising legs					

Social and Recreational	1	2	3	4	5
Bowling					
Jogging					
Swimming					
Ice skating					
Competitive sports					
Dating					
Golfing					
Dancing					
Skiing					
Roller skating					
Hobbies					
Dining out					

Activities of Daily Living: Using the following 1-5 scale, choose the number that describes the difficulties listed below.

1 = I can do it without any difficulty
2 = I can do it without much difficulty, despite SOME pain
3 = I manage to do it by myself, despite MARKED pain
4 = I manage to do it despite the pain, but only if I have help
5 = I cannot do it at all, because of the pain

Difficulties with Traveling	**1**	**2**	**3**	**4**	**5**
Driving a motor vehicle					
As a passenger in a motor vehicle					
As a passenger on a train					
Driving for long periods of time					
As passenger in an airplane					

For the 4 sections below, please use the following scale to that best represents your difficulties with Communication, senses, hand functions and sleep.

1 = This area is NOT affected by my condition
2 = This area is SLIGHTLY affected by my condition
3 = My condition MODERATELY restricts my ability in this area
4 = My condition SERIOUSY limits my ability in this area
5 = My condition PREVENTS me from using this ability

Difficulties with Communication	**1**	**2**	**3**	**4**	**5**
Concentrating					
Hearing					
Listening					
Speaking					
Reading					
Writing					
Using a keyboard					

Difficulties with Senses	**1**	**2**	**3**	**4**	**5**
Seeing					
Hearing					
Touch					
Taste					
Sense of smell					

Difficulties with Hand Functions	**1**	**2**	**3**	**4**	**5**
Grasping					
Holding					
Pinching					
Percussive movements					
Sensory discrimination					

Difficulties with Sleep	**1**	**2**	**3**	**4**	**5**
Being able to have a normal, restful nights sleep					

Prior Treatment Information:

Prior Similar Symptoms:

Please check the question that best explains your current symptoms:

_____ I have NOT had prior similar symptoms to current complaints

_____ My current complaints DID exist before, but had been dormant for:

Prior symptoms _____ # of months ago
_____ # of years ago

_____ My current complaints ALREADY existed and were worsened

Has your HISTORY contributed to your Symptoms?

_____ My history HAS contributed to my current symptoms

_____ My history HAS NOT contributed to my current symptoms

_____ I'm NOT SURE if my history has contributed to my symptoms

184 Mammoth Rd Unit 6
Londonderry, NH 03053
phone 603-434-8300 fax 603-965-1057

Auto Accident Billing Policy

All billing from our office, pertaining to your auto accident will be sent to your Insurance Company that you have listed below, for processing. Per New Hampshire State law (RSA 264:16), checks are mailed directly to you, the policyholder and **not** sent to our office.

Due to the NH state law, our office policy requires patients to pay for the services rendered at the time of your visit. This ensures that your account is paid and up to date.

In NH, when you are involved in an auto accident, you must open a Med-pay Claim with your own insurance company. The state of NH requires your insurance company to collect funds from the at-fault insurance company. We must bill to your insurance company for services rendered.

Claim number: _____

Insurance company: _____

Date of Accident: _____

Parent Chiropractic Center
J. Daniel Parent, D.C.
Tax ID # 02-0478056

_____ _____

Patient Signature **Date**

_____ _____

Parent/Guardian signature **Date**
(if patient under 18 years of age)

PARENT CHIROPRACTIC CENTER

Auto Accident Information sheet

Patient Name: _____

Date of Accident: _____

Insurance Company Information:

Patient Auto Insurance Company Name: _____
(NOT the at fault insurance co.)

Auto Insurance **Billing** Address: _____

City / state / zip _____

Telephone # of Auto Insurance Company: _____

Auto Insurance Claim Number: _____(not your policy number)

Auto Insurance Adjuster Name: _____

Adjuster Telephone Number (ext.): _____

Adjuster Fax Number: _____

Med Pay Amount: $_____

Any additional info: _____

Important to note: In the state of NH, you **MUST** open a claim with **YOUR** insurance company, we must bill to your insurance company. If you are not at fault, the insurance company will seek funds from the at-fault party's insurance company.

PARENT CHIROPRACTIC CENTER

Consent for Purpose of Treatment, Payment and Health Care Operations

I consent to the use or disclosure of my protected health information by J. Daniel Parent for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of J. Daniel Parent.

I understand that diagnosis or treatment of me by Parent Chiropractic Center may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or health care operations of the practice. Parent Chiropractic Center is not required to agree to the restrictions that I may request. However, if J. Daniel Parent agrees to a restriction that I may request. the restriction is binding on J. Daniel Parent and Parent Chiropractic Center.

I have the right to revoke this consent in writing, at any time, except to the extent that Parent Chiropractic Center or J. Daniel Parent has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information collected from me and created or received by my physician, another health care provider, a health plan, my employer, or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review J. Daniel Parent's Notice of Privacy Practices prior to signing this document.

The J. Daniel Parent's Notice of Privacy Practices has been provided to me.

The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of the Parent Chiropractic Center.

The Notice of Privacy Practices also describes my rights and the duties of Parent Chiropractic Center with respect to my protected health information.

The Notice of Privacy Practices for Parent Chiropractic Center is also provided at 184 Mammoth Road, Unit 6, Londonderry, NH 03053 and on the Parent Chiropractic Center web-site.

J. Daniel Parent reserves the right to change the privacy practices that are described in the Notices of Privacy Practices.

I may obtain a revised notice of privacy practices by accessing the Parent Chiropractic Center web-site, calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Patient Name or Personal Representative _____

Signature of Patient or Personal Representative _____

Date _____

Relationship to Patient _____

Notice of Privacy Practice Summary

This summary discloses how health information about you may be used. A full notice of your privacy rights has also been provided to you.

Parent Chiropractic Center uses health information about you for treatment, to obtain payment for treatment with your authorization as required (check your state laws), for administrative purposes and to evaluate the quality of care that you receive.

Parent Chiropractic Center will not disclose your information to others unless you tell us to do so or unless the law authorizes or requires us to do so.

Parent Chiropractic Center may use your information to provide appointment reminders and information about alternatives or other health-related issues.

Parent Chiropractic Center may disclose your information for public health activities, to funeral directors to enable them to carry out their activities, for organ and tissue donations, research health and safety, governmental function in order to comply with workers compensation laws and regulations a right to request restriction, report and retain a copy of your health record, request communication of your information by alternative means at alternative locations, revoke your authorization and request an accounting of your health records.

You may complain to the Privacy Officer Kelly Spitalere and to the Department of Health and Human Services if you believe your privacy rights have been violated. You will not be retaliated against for filing a complaint.

Parent Chiropractic Center must maintain the privacy of protected health information, provide you with notice of its legal duties and privacy practices with respect to your health information, abide by the terms of the notice, notify you if it was unable to agree to the requested restriction on how your information is used or disclosed, accommodate reasonable requests you may make to communicate with health information by alternative means or by alternative locations and obtain your written authorization to use or disclose your health information for reasons other than those listed above and permitted under law.

If you have any questions or complaints please contact Kelly Spitalere at 434-8300.

_____ _____

Patient Signature **Date**

TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective. Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental and social well being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease. We only offer to diagnose either vertebral subluxations or neuro-musculoskeletal conditions. However, if during the course of chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of another health care provider. Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. **OUR ONLY PRACTICE OBJECTIVE** is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations. However, we may use other procedures to help your body hold the adjustments.

I, _____ have read and fully understand the above statements.
(*print name*)

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction. I therefore accept chiropractic care on this basis.

_____ _____
(*signature*) (*date*)

Consent to evaluate and adjust a minor child

I, _____ being the parent or legal guardian of
_____ have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

Pregnancy Release
This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform a x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child. Date of last menstrual period: _____

_____ _____
(*signature*) (*date*)