Motor Vehicle Accident Information

Name _____ Today's Date _____

Accident Date _____ Claim # _____

Have you told your car insurance that you sustained personal injuries? _____

Name of Policy holder: _____ Policy # _____

Are they sending you an Accident Benefits Package in the mail? _____

Car Ins. Company _____ City of Branch Office _____

Adjuster: _____ Phone #_____ext _____
Fax:_____

Your Extended Health Coverage: (Sun Life etc) _____
Plan/Certificate # _____Identifier _____
How much chiropractic does it cover per year? _____

Spouse Extended Health Ins. _____ Plan/Certificate # _____
Identifier _____ Spouse's Name _____
How much chiropractic does it cover per year? _____
Date symptoms first appeared? _____
Date of first post-accident examination? _____

Circle all that apply since the auto accident and add any others not listed.

Headache	Shooting head pain	Fatigue
Depression	Ringing in the ears	Dizziness
Fainting	Loss of balance	Cold hands
Muscle Spasms	Grating in neck	Inner tension
Chest pain	Shortness of breath	Irritability
Swollen joints	Concussion	Shoulder tension
Leg/knee/foot pain	Painful joints	Pins & Needles Sensation
Throat pain	Eye/ear/face pain	Loss of taste
Memory loss	Loss of smell	Neck pain
Upper back pain	Low Back pain	Arm weakness
Cuts/scrapes	Bruising	Shoulder pain
Broken bone(s)	Cast	Other _____

_____

Have you previously seen any other health professional for this accident? If yes, Who?
_____ Phone # _____

Were you employed at the time of the accident? ____ If yes, are you seeking lost wages? _____for which dates? _____

If you were employed at the time of accident, are you able to perform the essential tasks of your employment since the accident? _____

Does your employer offer modified ____ graduated ____ work?

Were you enrolled in an education program at the time of the accident? _____

If yes, were you able to continue? ____ If no, days missed? _____

Were you the primary caregiver for anyone at the time of the accident? _____
If yes, who? _____

Did you suffer a substantial inability to carry out primary caregiver activities following the accident? _____

Are you able to perform housekeeping and home maintenance services since the accident? _____

Have you sustained an impairment that continuously prevents you from engaging in substantially all activities in which you ordinarily engaged before the accident?
_____

Have you experienced any other injuries since the accident? _____

AGGREMENT:

I agree to complete any necessary paper work as soon as possible and be treated by Dr. J. Scott Martin for my motor vehicle accident injuries. If my claim is denied by the insurance company for any reason, I understand that I will be responsible for the payment of all unpaid balances on my account.

Signed _____ *Date*_____

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