

Automobile Accident Questionnaire

Please answer all questions completely

Dear Patient: This information is considered confidential. We need this information because we care enough to want to know, and your answers will help us determine if chiropractic can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. In order for us to understand your condition properly, please be as neat and accurate as possible while completing this form. Thank you.

Name _____ Sex _____ Marital Status _____ DOB _____ Home Phone _____

Address _____ City _____ State _____ Zip _____

Occupation _____ Who referred you to our office? _____

Social Security # _____ Business Phone _____ Company Name _____

Spouse's First Name _____ Spouse's Soc. Sec. # _____ Spouse's Employer _____

Please explain in detail how your accident happened _____

What were the time and date of present injury? _____

Where did you feel pain immediately after the accident? _____

List the extent of your injuries as you know them: _____

Did you require post accident hospitalization? Yes No

Check symptoms you have noticed since the accident:

- | | | | |
|--|---|--|-------------------------------------|
| <input type="checkbox"/> Headache | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Depression | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Stomach Upset | <input type="checkbox"/> Light Bothers Eyes | <input type="checkbox"/> Buzzing in Ears | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Head Seems too Heavy | <input type="checkbox"/> Loss of Memory | <input type="checkbox"/> Feet Cold |
| <input type="checkbox"/> Neck Stiff | <input type="checkbox"/> Pins and Needles in Arms | <input type="checkbox"/> Ears Ring | <input type="checkbox"/> Hands Cold |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Sleeping Problems | <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Back Pain |
| <input type="checkbox"/> Face Flushed | <input type="checkbox"/> Pins and Needles in Legs | <input type="checkbox"/> Constipation | <input type="checkbox"/> Tension |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Numbness in Fingers | <input type="checkbox"/> Loss of Smell | <input type="checkbox"/> Fever |
| <input type="checkbox"/> Irritability | <input type="checkbox"/> Numbness in Toes | <input type="checkbox"/> Loss of Taste | <input type="checkbox"/> Chest Pain |
| <input type="checkbox"/> Cold Sweats | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> _____ | <input type="checkbox"/> _____ |

Symptoms other than above: _____

Where were you taken after the accident? _____

Hospitalized? Yes No If yes, admitted? _____ How long? _____

Name of Hospital _____

Name of Doctors _____

What treatment was given? _____

Was any other doctor consulted after your accident? Yes No

If so, what was the doctor's name? _____ D.C., M.D., D.O., D.D.S.

What was the diagnosis? _____

What treatment was given? _____
 How often did you see the doctor? _____
 How long did you see the doctor? _____
 Have you ever had any complaints in the involved area before? Yes No
 If so, what were the complaints? _____
 Before the injury were you capable of working on an equal basis with others your age? Yes No
 Are your work activities restricted as a result of this accident? Yes No
 Since this injury are your symptoms Improving? Getting worse? Same?

Drive of other vehicle (if any)
 Name _____ Insurance Company _____ Policy No. _____

Driver of vehicle in which you were injured (if applicable)
 Name _____ Insurance Company _____ Policy No. _____

Name of your insurance adjustor _____

Have you retained an attorney? Yes No

If so, his name and address _____

You were heading North East South West on _____ (street or highway)

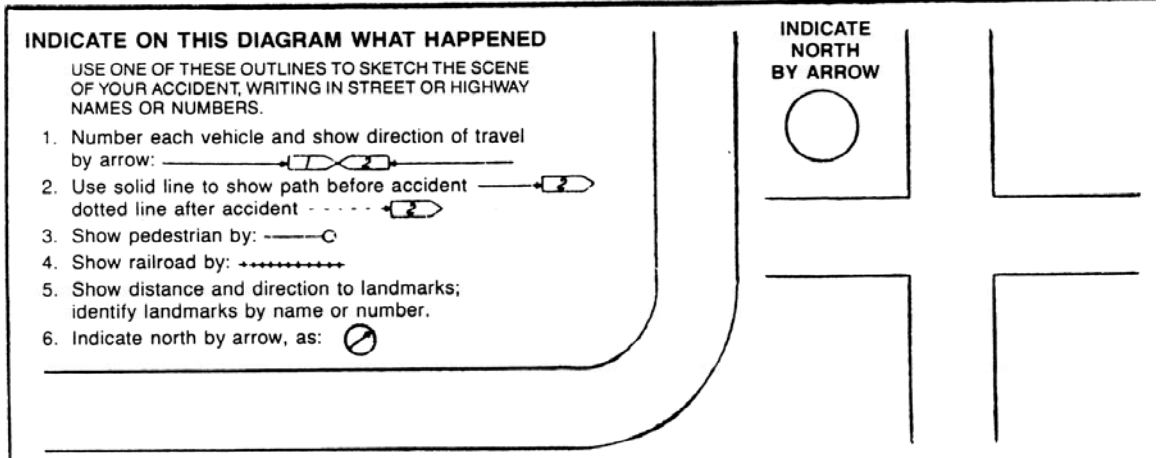
Other vehicle was heading North East South West on _____ (street or highway)

Were police notified? Yes No

Were you knocked unconscious? Yes No If so, for how long? _____

You were struck from Behind Front Left Side Right Side

You were Driver Passenger Front seat Back Seat Using seat belts



I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this Chiropractic Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this Chiropractic Office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Patient's Signature: _____

Guardian or Spouse's Signature: _____ Date _____

DOCTOR'S LIEN

TO: Attorney/Insurance Carrier

Doctor

Dr. Desiree Kiehn D'Agostino
651 Boylston Street, Ste 2.
Boston, MA 02116

RE: Patient records and doctor's lien

I do hereby authorize the above doctor to furnish you, my attorney/insurance carrier, with a full report of her case history, examination, diagnosis, treatment, and prognosis of myself in regard to my accident/illness which occurred/began on _____.

I hereby give a lien to said doctor on any settlement, claim, judgment, or verdict as a result of said accident/illness, and authorize and direct you, my attorney/insurance carrier, to pay directly to said doctor such sums as may be due and owing her for service rendered me, and to withhold such sums from such settlement, claim, judgment, or verdict as may be necessary to protect said doctor adequately.

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

Dated: _____ Patient's signature: _____

The undersigned, being attorney of record or authorized representative of insurance carrier for the above patient does hereby acknowledge receipt of the above lien, and does agree to honor the same to protect adequately said above named doctor.

Dated: _____ Authorized signature: _____

NOTICE: Please date, sign, and return one copy to doctor's office at once. Keep one copy for your records.

AFFIDAVIT OF HEALTH INSURANCE

I, _____, hereby state that I do not have any private health insurance which would cover my medical bills in excess of \$2000.00 in relation to injuries sustained by me in a motor vehicle accident which occurred on _____.

Signature of Patient

Witness: _____

AFFIDAVIT OF HEALTH INSURANCE

I, _____, hereby state that I do not have any private health insurance which would cover my medical bills in excess of \$2000.00 in relation to injuries sustained by me in a motor vehicle accident which occurred on _____.

Signature of Patient

Witness: _____

AFFIDAVIT OF HEALTH INSURANCE

I, _____, hereby state that I do not have any private health insurance which would cover my medical bills in excess of \$2000.00 in relation to injuries sustained by me in a motor vehicle accident which occurred on _____.

Signature of Patient

Witness: _____

We will not be charging you directly. Please fill out this form so that we may bill your auto carrier for chiropractic services received as a result of your automobile accident.

AUTHORIZATION TO PAY PHYSICIAN

I hereby authorize the _____ Insurance Company to pay by check made out and mailed directly to:

Dr. Desiree Kiehn D'Agostino
651 Boylston St. Suite #2
Boston, MA 02116

The medical expense benefits otherwise payable to me under my current insurance policy, as payment toward the total charges for Professional Services Rendered. This payment will not exceed my indebtedness to above mentioned assignee and I have agreed to pay, in a current manner, any balance of said Professional Service charges over and above this insurance payment.

Signed: _____

Date: _____

(Name)

(Street Address)

(City) (State)