

ACCIDENT INFORMATION

Date and time of Accident: _____ First Name: _____ Last Name: _____
Name of the location/Street on which you were traveling: _____
Where you the: Driver Front Passenger Rear Passenger
Make and model of the vehicle you were occupying: _____
Was this vehicle equipped with airbags? Yes No Did the Airbags inflate? Yes No Were you wearing a seatbelt? Yes No
Did the impact to your vehicle come from the : Front Rear Right Side Left Side Other
In relation to the base of your skull, where was the headset? Above Below At the base
In which direction were you headed? North South East West
Direction the other vehicle was headed? North South East West
During impact, were you facing: Forward Right Left
Did any part of your body strike anything in the vehicle? Yes No Explain: _____
Did the accident render you unconscious? Yes No If yes, for how long? _____
What was the approximate speed of your vehicle? _____ The OTHER vehicle? _____
Were you Aware Surprised by the impact.
What did your vehicle impact? A Vehicle Other If other, please explain: _____
Number of people in the accident vehicle: _____ Please list the names of the victims in this accident: _____

In your own words, please describe the accident: _____

Please describe how you felt immediately after the accident: _____

LEGAL INFORMATION

Did the police come to the accident scene? Yes No Was a police report filed? Yes No
Were there any witnesses? Yes No Was a traffic violation issued? Yes No To whom: _____
Have you retained an attorney? Yes No If yes, whom? _____ Phone: _____

MEDICAL INFORMATION

Have you gone to a hospital or seen any other doctor? Yes No When did you go? Immediately Next Day Two Days Plus
How did you get there? Ambulance Private Transportation Was medication prescribed? Yes No
Name of the hospital and/or attending doctor: _____
Was he/she a: D.D.S M.D. D.C. D.O. Were any X-rays taken? Yes No
Have you been able to work since this injury? Yes No Are your work activities restricted as a result of this injury? Yes No

INSURANCE

Primary Insurance _____	Secondary Insurance _____
Insurance Phone _____	Insurance Phone _____
Policy ID or Claim# _____	Policy ID or Claim# _____
Insurance Address _____	Insurance Address _____
_____	_____

CERTIFICATION & ASSIGNMENT

I certify that I, and/or my dependent(s) have insurance coverage with _____
And assign directly to Ord Sports Chiropractic & Wellness all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

PAYMENT POLICY

The above named Chiropractic clinic (Ord Sports Chiropractic & Wellness) may use my healthcare information and may disclose such information to the above named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below. I understand regardless of my insurance status, I am ultimately responsible for any charges for professional services rendered by Ord Sports Chiropractic & Wellness.

Signature of Patient, Parent, Guardian or Personal Representative

Date _____