AUTO ACCIDENT FORM

About The Patient

BEHYMER & STEEL CHIROPRACTIC 1043 Stuart St., #100 Lafayette, CA 94549

Name_____ Today's Date _____ Birthdate_____ Age_____

Address_____ City_____ State_____ Zip_____

Home Phone_____ Cell Phone_____ Work Phone_____ Gender ☐M ☐F

Employer_____ Type of Work_____

e-Mail Address_____ Have You Been To A Chiropractor Before? ☐Yes ☐No

Significant Other's Name_____ Social Security #:_____

Emergency Contact_____ Phone #_____

Name of Medical Doctor(s)_____

How Did You Hear About Our Office? _____

By signing below I authorize the following…

I authorize the doctor or his staff to render care as deemed appropriate for me and /or my child.
I authorize the Behymer & Steel Chiropractic staff to request records from other providers as may be necessary.
I understand that I am responsible for all balances of bills incurred in this office that are not covered by insurance.
I authorize assignment of my insurance benefits (if applicable) directly to the provider.

_____ _____

Patient / Parent Signature Date

Insurance Information

DRIVER'S CAR INSURANCE

Car Insurance Company_____ Policy # _____

Has your car insurance company been notified of the accident? ? □Yes □No

Accident Claim # _____

Name of Adjuster Handling Claim _____ Contact Phone (_____) _____-_____

Address_____ City_____ State_____ Zip_____

YOUR HEALTH INSURANCE

Health Insurance Company_____ Policy # _____

Address_____ City_____ State_____ Zip_____

Phone(_____) _____-_____

About the Crash

Describe the Accident _____

_____

Date of Accident _____ Total passengers in car during impact _____

1. Were you the □Driver □Front/Back Passenger Were you wearing a seatbelt □Yes □No
2. What was the speed of your car at the time of the accident? _____
3. What was the speed of the oncoming car or object at the time of impact? _____
5. At the point of impact where were you looking? □Forward □Right □Left
6. Were you aware that the impact was going to happen? □Yes □No
7. Did you hit your head on impact? □Yes □No
8. Did you go to the hospital? □Yes □No If yes, which Hospital? _____

Reason For Seeking Care

PAIN & SYMPTOMS FOLLOWING ACCIDENT

1. _____ **How long is this been an issue?** _____

Is it: □Dull □Sharp □Ache □Numb / Tingle □Stabbing □Constant □Occasional □Staying the same □Getting worse

□Mild □Moderate □Severe □Worse in the morning □Worse in the evening □Pain radiates to _____

2. _____ **How long is this been an issue?** _____

Is it: □Dull □Sharp □Ache □Numb / Tingle □Stabbing □Constant □Occasional □Staying the same □Getting worse

□Mild □Moderate □Severe □Worse in the morning □Worse in the evening □Pain radiates to _____

3. _____ **How long is this been an issue?** _____

Is it: □Dull □Sharp □Ache □Numb / Tingle □Stabbing □Constant □Occasional □Staying the same □Getting worse

□Mild □Moderate □Severe □Worse in the morning □Worse in the evening □Pain radiates to _____

4. _____ **How long is this been an issue?** _____

Is it: □Dull □Sharp □Ache □Numb / Tingle □Stabbing □Constant □Occasional □Staying the same □Getting worse

□Mild □Moderate □Severe □Worse in the morning □Worse in the evening □Pain radiates to _____

5. Does your condition affect:

□ Sleep □Work □Daily Routine □Sitting □Driving

6. What makes it better?

7. What makes it worse?

8. List any past auto collisions: _____

Was any care received? □Yes □No

9. What Doctors have you seen for the Accident? _____

_____

10. Type of treatment? _____

11. Results _____

Notes _____

_____