balance chiropractic • PLLC

Auto Accident Form

Patient Registration Date_____

Patient Name: _____ Date of Birth: _____
Address: _____ SS#_____
City, State, Zip: _____
Home Phone: _____ Work Phone: _____ M____ F___

Date of Injury: _____ Part(s) of Body Injured: _____

Are you allergic to any medications? No___ Yes___ If yes, please list:
_____

Do you have private health insurance? No___ Yes___

Please have Receptionist make a copy of your health card

Health insurance company:_____
Telephone:_____ Policy ID:#_____
Group #:_____
Primary Card Holder:_____
Primary Card Holder's Employer:_____
Your Relationship to Primary Card Holder: Child Spouse Other:_____

Name of Primary Physician_____ Phone#:_____

Have you treated at any of our facilities before? No___ Yes___
If yes, where?_____

Have you treated anywhere else for this injury? No___ Yes___
If yes, where?_____

Automobile Insurance Information:

Vehicle #1
(vehicle YOU were in at time of accident)
Insured's Name:_____
Address:_____
City, State, Zip :_____
Auto Insurance Co.:_____
Telephone:_____
Claim#:_____
Name of Adjuster:_____
Policy#_____

Vehicle#2
(other vehicle involved)
Insured's Name:_____

Auto Insurance Co.:_____
Address:_____
Telephone:_____
Claim#:_____
Name of Adjuster:_____
Policy#:_____

In this accident, were you the: Driver Passenger Pedestrian

Please describe how the accident occurred:
_____
_____
_____
_____
_____

Did you lose consciousness: NO___ YES___
(how long?) _____

Were you wearing a seat belt? NO___ YES___
Was your vehicle **stopped** or **moving** at the time of the accident? _____
Were you transported by ambulance? NO___ YES___
Were X-Rays taken? NO___ YES___
Have you ever been in an auto accident before?
If yes, what year?_____

Employer Information
Company Name: _____
Telephone: _____
Address:_____
City, State, Zip: _____
Contact person: _____

I certify, under the pains and penalties of perjury, that the information contained in these forms is true and accurate to the best of my knowledge and will promptly notify you of any changes of inaccuracies.

_____
Patient Signature(or Parent if Patient is a minor) Print Name Date