PROSPER CHIROPRACTIC & WELLNESS CENTER

Auto/ Personal Injury Related Accident

John H Perriton, D.C.
Travis W. Sullivan, D.C.
101 E Broadway St
Prosper, TX 75078

ABOUT YOU

Today's Date: _____ **Completed By (circle one):** Self / Guardian / Power of Attorney

Patient Legal Name: _____ **DOB:** _____

AUTO RELATED ACCIDENT

Date of Accident: _____ Time of Accident: _____ AM / PM
Were you the (circle one): Driver / Front Passenger / Rear Passenger Number of people in the car: _____
Did the police come: YES / NO Was a police report filed: YES / NO Were there any witnesses: YES/ NO
If a traffic violation was issued, to whom was it issued: _____
Were you wearing your seat belt: YES / NO Did air bags inflate: YES / NO
In relation to the base of your skull, where was the head rest (circle one): Above / Below / At base of skull
What did your vehicle impact: Another vehicle / Other: _____
Did any part of your body strike anything in the vehicle: YES / NO If yes, explain: _____
Make & Model of the vehicle you were in: _____
Name of location / street (and state) on which you were traveling: _____
In which direction you were headed: N / E / S / W Speed of your vehicle: _____
Did the impact to your vehicle come from: Front / Rear / Right side / Left side / Other: _____
During impact, were you facing: Left / Right / Forward / Other: _____
Were you Aware or Surprised by the impact? (circle one)
If accident made impact with another vehicle:
Make & Model of other vehicle: _____
Direction other vehicle was traveling: N / E / S / W Speed of other vehicle: _____
In your own words, please describe the accident:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Name of Person Completing Registration (print): _____

Patient / Guardian (if minor) signature: _____ **Date:** _____

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PATIENT NAME: _____ Date of Birth: _____

AFTER INJURY

Did the accident render you unconscious: YES / NO If yes, for how long: _____
Please describe how you felt immediately after the accident: _____
Have you gone to a hospital or seen any other physician: YES / NO
If yes, when: Just after accident / Next day / 2 days plus How did you get there: Ambulance / Private transportation
Name of hospital or doctor's office: _____ Was he/she a: D.C. / M.D. / D.O. / D.D.S
Describe any treatment received: _____
Were X-Rays taken: YES / NO Was any medication prescribed: YES / NO
Have you been able to work since the injury: YES / NO Are your work activities restricted: YES / NO
Indicate the symptoms that are a **RESULT** of the accident:

☐ Dizziness	☐ Difficulty sleeping	☐ Jaw problems	☐ Nausea
☐ Memory loss	☐ Irritability	☐ Arms/Shoulder pain	☐ Back pain
☐ Headaches	☐ Fatigue	☐ Numb hands/fingers	☐ Lower back pain
☐ Blurred vision	☐ Tension	☐ Chest pain	☐ Back stiffness
☐ Buzzing in ear	☐ Neck pain	☐ Shortness of breath	☐ Leg pain
☐ Ears ringing	☐ Neck stiffness	☐ Stomach upset	☐ Numb feet/toes

Is your condition getting worse: YES / NO / CONSTANT / COMES & GOES
Indicate your degree of comfort while performing the following activities:

	N/A	Comfortable	Uncomfortable	Painful
Lying on back	0	1	2	3
Sitting	0	1	2	3
Standing	0	1	2	3
Stretching	0	1	2	3
Walking	0	1	2	3
Running	0	1	2	3
Working	0	1	2	3
Sports	0	1	2	3
Lifting	0	1	2	3
Bending	0	1	2	3
Pulling	0	1	2	3
Kneeling	0	1	2	3
Reaching	0	1	2	3

Have you retained an attorney: YES / NO
If Yes, who:
_____
Phone #:
_____

Do you have ACTIVE military status: YES / NO

Do you have active Medicaid / Medicare (circle one) coverage? YES / NO

RECOVERY

To evaluate the effect that continuing work will have on your recovery please complete the following:
How many hours are in your normal work / school day:_____
Please indicate your daily normal daily duties and any activities which you are occasionally asked to perform:

☐ Standing	☐ Driving	☐ Operating equipment
☐ Sitting	☐ Twisting	☐ Work with arms above head
☐ Walking	☐ Crawling	☐ Typing
☐ Lifting	☐ Bending	☐ Stooping

☐ Other_____

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PATIENT NAME: _____ Date of Birth: _____

INJURY VERIFICATION

3RD PARTY INSURANCE INFORMATION (other person's car insurance)

Insured: _____

Insurance Co Name: _____ Ins Co Phone #: _____

Adjuster: _____ Adjuster Phone #: _____

Claim #: _____

OFFICE USE ONLY: (PATIENTS DO NOT COMPLETE)

Has insurance accepted liability: _____

Medical Claims Address: _____

Medical Claims Fax: _____

Email: _____

Date of Accident on file: _____

PATIENT PERSONAL AUTO INSURANCE (your car insurance)

Insured's Name: _____ Insured DOB: _____

Insurance Co Name: _____ Ins Co Phone#: _____

Policy #: _____ Claim #: _____

Medical Adjuster Name: _____ Adjuster Phone #: _____

OFFICE USE ONLY:

Medical Claims Address: _____

Medical Claims Fax: _____

Email: _____

PIP / Med Pay limit: _____

TO THE PATIENT: I understand that although *Prosper Chiropractic & Wellness Center* will file claims for me, I accept full financial responsibility for my care and will pay any portion not covered by insurance. I understand I AM RESPONSIBLE FOR ALL CHARGES INCURRED.

Name of Person Completing Registration (print): _____

Patient / Guardian (if minor) signature: _____ **Date:** _____

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PATIENT NAME: _____ Date of Birth: _____

SIGNATURE ON FILE

I authorize use of this form on all my insurance submissions.

I authorize release of information to **all my Insurance Companies**.

I understand that **I am responsible** for all my bills regardless of third-party liability.

I authorize my doctor to act as my **agent** in helping me obtain payment from my insurance companies.

I **permit** a copy of this authorization to be used in place of the original.

I authorize payment directly to my doctor.

By my signature I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. I recognize that *Prosper Chiropractic & Wellness Center* physicians and providers are offering me an additional service by filing my insurance claims and waiting for their payment. I am aware that *Prosper Chiropractic & Wellness Center* providers reserve the right to revoke this assignment and demand payment for services rendered should difficulties arise in collecting payment form my insurance company, or if for any reason my care is discontinued at this office.

Name of Person Completing Registration (print): _____

Patient / Guardian (if minor) signature: _____ **Date:** _____