

Patient Accident Questionnaire

Date of Accident: _____ Hour: _____ AM _____ PM _____

Specific Location of Accident: _____

Describe in detail, in your own words, how the accident happened: _____

In the accident: Were you the Driver Passenger Pedestrian Other? _____

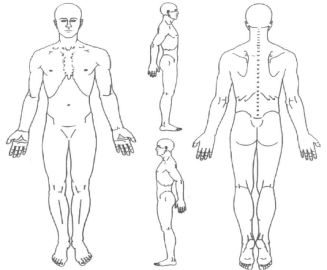
Did your car strike the other vehicle? Yes No **Did the other car strike your car?** Yes No

Were you struck from: Behind Front Side Impact Driver's Side Passenger's Side

Were traffic citations issued to: You the Driver of Your Car the Driver of the Other Car No Citations Given

Was your car heading: North South East West on _____ (Street/Highway)

Was the other heading: North South East West on _____ (Street/Highway)

<p style="text-align: center;">Please mark on the diagram to the right the following symbols as they relate to the patients' symptoms:</p> <p>SS = spasms ST = stiffness DP = dull pain SP = sharp pain SH = shooting pain TI = tingling NU = numbness O = Other</p>	
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CHECK ANY OF THE FOLLOWING SYMPTOMS YOU HAVE NOTICED SINCE THE ACCIDENT:

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Headache | <input type="checkbox"/> Middle Back Pain | <input type="checkbox"/> Lower Back Pain | <input type="checkbox"/> Ears Ring |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Lower Back Stiffness | <input type="checkbox"/> Buzzing in Ears |
| <input type="checkbox"/> Neck Stiffness | <input type="checkbox"/> Bruised Chest | <input type="checkbox"/> Radiating Pain | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Sleeping Problems | <input type="checkbox"/> Bruising Anywhere | <input type="checkbox"/> Tingling in Legs | <input type="checkbox"/> Loss of Smell |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Blurred Vision | <input type="checkbox"/> Tingling in Arms | <input type="checkbox"/> Loss of Taste |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Sensitivity to Light | <input type="checkbox"/> Jaw Pain | <input type="checkbox"/> Any Burns |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Upper Arm Pain | <input type="checkbox"/> Upper Leg Pain | <input type="checkbox"/> Any Stitches |
| <input type="checkbox"/> Muscle Spasms | <input type="checkbox"/> Lower Arm Pain | <input type="checkbox"/> Lower Leg Pain | <input type="checkbox"/> Any Cuts |

Have you lost time from work? Yes No: If Yes, Dates: _____ to _____

Employer: _____ Employers Telephone: _____

Did you go to the hospital? Yes No: If Yes, Name of Hospital or E.R.: _____

Address: _____ Date of Hospitalization: _____

Attending E.R. Doctor: _____ Treatment Given? _____

DO YOU HAVE A HISTORY OF ANY OF THE FOLLOWING DISEASES?:

- | | | | |
|---|--|--|---|
| Tuberculosis <input type="checkbox"/> Yes | Lung Disease <input type="checkbox"/> Yes | Gout <input type="checkbox"/> Yes | Diabetes <input type="checkbox"/> Yes |
| Kidney Disease <input type="checkbox"/> Yes | Stomach/Ulcer <input type="checkbox"/> Yes | Heart Disease <input type="checkbox"/> Yes | Hepatitis <input type="checkbox"/> Yes |
| Sciatica <input type="checkbox"/> Yes | Blood Pressure <input type="checkbox"/> Yes | Transfusion <input type="checkbox"/> Yes | Polio / MS <input type="checkbox"/> Yes |
| Colon Disease <input type="checkbox"/> Yes | Stroke <input type="checkbox"/> Yes | Cancer <input type="checkbox"/> Yes | Bleeding <input type="checkbox"/> Yes |
| Paralysis <input type="checkbox"/> Yes | Seizures <input type="checkbox"/> Yes | Arthritis <input type="checkbox"/> Yes | Asthma <input type="checkbox"/> Yes |
| Anemia <input type="checkbox"/> Yes | Thyroid Disease <input type="checkbox"/> Yes | Drug Dependence <input type="checkbox"/> Yes | AIDS <input type="checkbox"/> Yes |

Patient Signature: _____

Date: _____

PLEASE CHECK (✓) AS MANY OF THE FOLLOWING STATEMENTS THAT APPLY TO YOUR CASE.

- I have medical payment (Med-Pay) benefits, either, personally or through the driver of my vehicle.
- I have group health insurance benefits either directly or through my spouse or parents.
- I have retained an attorney.**
- I have not retained an attorney.**
- I have the adverse or third party information available. (Insurance company of the other driver.)

PLEASE PROVIDE THE APPROPRIATE INSURANCE INFORMATION:

1) YOUR AUTOMOBILE INSURANCE CARRIER: _____

Address: _____ Telephone: (____) _____ Insured: _____

Claim #: _____ Policy #: _____

Telephone: (____) _____ Fax: (____) _____

2) YOUR GROUP HEALTH INSURANCE COMPANY: _____

Address: _____ Telephone: (____) _____ Insured: _____

Date of Birth: _____ Policy #: _____ SS#: _____

Telephone: (____) _____ Fax: (____) _____

3) ADVERSE OR THIRD PARTY AUTOMOBILE INSURANCE CARRIER: _____

Address: _____ Telephone: (____) _____ Claims Rep: _____

Claim #: _____ Policy #: _____ Insured: _____

Telephone: (____) _____ Fax: (____) _____

4) Attorney: _____ Legal Assistant: _____

Address: _____

Telephone: (____) _____ Fax: (____) _____

Authorization to Release Medical Information: I authorize the release of any medical information necessary to process my insurance claim (s) and also certify that all insurance information given to this clinic is correct and complete.

Request for Payment of Benefits to Provider of Care: I hereby authorize the Insurance Company/Insurance Administrator to pay by check, and for it to be mailed directly to AZ MultiCare the expense benefits allowable and otherwise payable to me under my current policy, as payment toward the total charges for professional services rendered. I have agreed to pay, in a current manner, any balance of said applicable charges. I agree that this office be given power of attorney to endorse/sign my name on any and all drafts for payment of my bill.

HIPAA Compliance

AZ MultiCare Chiropractic Office is required by law to maintain the HIPAA Notice of Privacy Practices. This notice explains our legal duties and privacy practices with respect to your protected health information. Signature below acknowledges that I have read this Notice of our Privacy Practices, Authorization to Release Medical Information & Request for Payment of Benefits to a Provider of Care A copy will be provided to me upon request.

Patient's Name: _____

Patient Signature: _____ Date: _____

Witness: _____ Date: _____