



Chugach Chiropractic Clinic LLC

Automobile Accident Questionnaire

Name: _____ Date: _____

1. Date of Accident: _____ Time: _____ a.m./p.m.

2. Driver of car: _____ Where you were seated: _____

3. Owner of car: _____ Year and Model of car: _____

4. Visibility at time of accident: poor/fair/good/other: _____

5. Road conditions at time of accident: icy/rainy/wet/clear/dark/other: _____

6. Where was your car struck? right/left/rear/front/side/other: _____

7. Type of accident: head-on collision broad-side collision rear-end collision
 front impact, rear-ended car in front non-collision: _____

8. What part of the car was damaged? _____

9. Describe what happened to you upon impact? _____

10. Did you see the accident was about to happen? Yes No

11. Did you brace for impact? Yes No

12. Were you wearing a seatbelt? Yes No

13. Were you wearing a shoulder harness? Yes No

14. Does the car have headrests? Yes No

15. If yes, what was the position of your headrest?

top of headrest even with bottom of head top of headrest even with top of head

top of headrest even with middle of head

16. Was your car braking? Yes No Was the other car braking? Yes No

17. Was your car moving at the time of the accident? Yes No If yes, how fast would you estimate you were going? _____

18. How fast would you estimate the other car was traveling? _____

19. What was the position of your head and body at the time of impact?

head turned left/right body straight in sitting position

head looking back body rotated left/right

head straight forward other: _____

20. At the time of the accident, recall what parts of your head or body hit what parts of the vehicle:

21. As a result of the accident were you: rendered unconscious dazed other: _____

22. Could you move all parts of your body? yes no

If no, why not? _____

23. Were you able to get out of the car and walk unaided? yes no

If no, why not? _____

24. Did you have any cuts or bruises from this accident? yes no

Insurance Information

Patient's personal insurance:

Insured's name (if other than patient) _____ Policy #: _____
Insurance Company Name: _____ Phone#: _____
Address: _____ City: _____ State/Zip: _____
Claim #: _____ Adjuster's name/phone: _____

Other party's insurance:

Insured's name (if other than patient) _____ Policy #: _____
Insurance Company Name: _____ Phone#: _____
Address: _____ City: _____ State/Zip: _____
Claim #: _____ Adjuster's name/phone: _____

Other insurance:

Insured's name (if other than patient) _____ Policy #: _____
Insurance Company Name: _____ Phone#: _____
Address: _____ City: _____ State/Zip: _____
Claim #: _____ Adjuster's name/phone: _____

Patient's Demographic Information

Patient's full name: _____ Social Security #: _____
Address: _____ Date of Birth: _____
Mailing address (if different): _____ Phone: _____
Employer name: _____ Occupation: _____
Employer's address: _____ Work phone: _____
Spouse's name: _____ Spouse's Social Security #: _____
Spouse's employer: _____ Occupation: _____

Assignment of Payment

My attorney and/or insurance carrier are hereby requested and authorized to pay direct to Chugach Chiropractic Clinic LLC any monies due on account, the same to be deducted from any settlement made on my behalf.

Further, I agree to pay Chugach Chiropractic Clinic LLC the difference, if any between the total amount of charges on my account and the amount paid by the attorney and/or insurance carrier. It is further understood that I, the undersigned agree to pay Chugach Chiropractic Clinic LLC the full amount of charges on my account should my condition be such that it is not covered by my policy or if for any reason the insurance carrier refuses to pay my claim.

Patient's signature: _____ Date: _____

Printed name: _____

Witness: _____



Chugach Chiropractic Clinic LLC

11462 Business Boulevard, Eagle River, Alaska 99577

(907) 694-9224 ♦ Fax: (907) 694-1066

www.careforyourspine.com

DOCTORS LIEN /ASSIGNMENT OF PAYMENT

I _____ do hereby request and authorize my attorney and/ or the insurance carrier to pay Chugach Chiropractic Clinic LLC any monies due on account, the same to be deducted from any settlement made on my behalf for injury date of _____.

Further, I agree to pay Chugach Chiropractic Clinic LLC the difference, if any between the total amount of charges on my account and the amount paid by the attorney and /or insurance carrier. It is further understood that I the undersigned agree to pay Chugach Chiropractic Clinic LLC the amount of charges on my account should my condition be such that it is not covered by the insurance carrier, or if for any reason the insurance carrier refuses to pay this claim.

Patient's Signature: _____ Date: _____

Printed Name: _____

Witness: _____