Motor Vehicle Accident Form

Patient Name (Last, First)	Date

Accident Details	
I was the/a _____ in the accident (fill in the blank):	□ Driver □ Passenger
Where did the accident occur?	
Which part of your car was impacted?	
Briefly describe the incident:	
How fast was your car traveling?	________________ MPH
How fast was the other car traveling?	________________ MPH
Did you hit your head during the accident?	□ Yes □ No □ Unsure _____________________
Were you wearing your seatbelt?	□ Yes □ No □ Unsure _____________________
Did the air-bags deploy?	□ Yes □ No □ Unsure _____________________
Did you lose consciousness at any point?	□ Yes □ No □ Unsure _____________________
Did you notice any bleeding during the accident?	□ Yes □ No □ Unsure _____________________
Did you feel pain immediately following?	□ Yes □ No □ Unsure _____________________
Have you experienced any of the following?	□ Headaches □ Nausea/Vomiting □ Dizziness

Treatment Details	
Please list all hospitals, clinics, practices, and physicians you have gone to for treatment:	
Please check any/all treatments you have received since the accident:	□ X-Rays □ MRI □ CT □ Lab Work □ Physical Therapy □ Chiropractic □ Other ______________________________
Did you receive any prescriptions for treatment of your injuries?	□ Yes □ No
Are you still receiving regular treatment for your injuries?	□ Yes □ No

Insurance Claim Information	
Insurance Carrier Handling Your Claim	*Claim Number*
Claims Adjuster	*Phone Number*

Terms & Agreement

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any account balances. I also authorize Belmont Chiropractic or my insurance company to release any information required to process my insurance claims.

Patient / Parent / Guardian Signature	*Date*

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