MASCALI CHIROPRACTIC
EST.1986

ACCIDENT FORM

Patient Information

Today's Date ___/___/_____

Last_____ First_____ Middle_____

Birthdate___/___/_____ Address_____

City_____ State_____ Zip_____

Phone Numbers (cell)_____(home)_____

Employer_____Occupation_____

Contact Name_____ Phone Number_____

Auto Accident Information- fill if applicable

Date of accident____ /_____ /_____ Time of accident_____ am / pm

Location of accident_____ Road Conditions_____

Describe the accident in your own words _____

_____

Where were you seated in the vehicle?_____

Did you lose consciousness upon impact? **Yes No**

Did any part of your body contact the inside of the vehicle? **Yes No**

If so, please describe here _____

_____

Were you wearing a seatbelt? **Yes No**

If yes, did you receive any injury or bruising from the seatbelt? **Yes No**

At the time of the accident or just after did you become or experience any of the following?

☐ Disoriented ☐ Confused ☐ Dizzy ☐ Nauseated ☐ Blurred Vision ☐ Loss of Balance ☐ Lightheaded
☐ Ringing/Buzzing in Ears Still experiencing these symptoms? **Yes No**

Did you go to the hospital? **Yes No** If yes, when? _____

Name of hospital? _____

What did the hospital do for your injuries? (collars, splints, imaging, medication, surgery, etc.)

_____

What was the diagnosis? _____

What was recommend for follow-up care? _____

Other health practitioner consulted after your accident? **Yes No**

If yes, please complete information below:

Dr. _____ Specialty:_____

Date first seen:_____ /_____ /_____

Type of treatment:_____

Are you still receiving treatment? _____

Was this accident on the job? **Yes No** Is there a police report? **Yes No**

For *****Auto Accident*, proceed to next page.**

For *****Work Accident*, fill out the rest of this page.**

Nature of accident_____

Describe the accident in your own words _____

_____

Lost time at work? **Yes No** Amount of time to date : _____

Workman's Comp Insurance Information:

Name of Company: _____

Address for Claims: _____

_____

Claim # : _____

Name and Phone Number of Adjuster: _____

** Name and phone number of supervisor: _____

Additional Notes:

_____

_____

Medical Payment information

In order to file your Med-Pay Claim our office must have the following information ***prior to treatment****:*

Name of Patient: _____
Date of Birth: _____Date of Accident: _____

The Insurance Company insuring the vehicle you were in at the time of the accident.

Name: _____

Claims Address: _____

_____

Adjuster's Name: _____

Phone Number: _____

MED PAY CLAIM NUMBER: _____

I, hereby, authorize and direct my insurance company, attorney or insurance adjuster to promptly pay Edward J. Mascali, DC any monies due and owed him for fees incurred for chiropractic services rendered and to withhold such sums from any settlement, judgement or verdict as may be necessary to fully compensate said doctor.
I understand that I am fully and directly responsible to Dr. Mascali for all fees incurred in his office and for care rendered to me. I further understand that such payment is not contingent on any settlement, judgement or verdict by which I may eventually recover said fee.

Signature Date