ACCIDENT CASE HISTORY

NAME (FULL FORMAL):_____(PREFERRED NAME: _____)

ADDRESS:_____

CITY: _____ STATE: _____ ZIP: _____+_____

CELL#_____HOME# _____

EMAIL:_____

EMERGENCY CONTACT- Name:_____#(_____)_____

Communication Consent - Circle one: Text / Email / Both / None for appointment reminders, etc.

DATE OF BIRTH: _____ AGE: _____ GENDER: MALE / FEMALE

SSN: _____ MARITAL STATUS: S / M / D / W

Date of Accident_____ Hour _____am / pm

State Location of accident TN / GA / OTHER: _____

Have You Lost Any Days at Work: Y / N Dates:_____

Other Doctors Seen for This Condition: _____

List Medications or Drugs You Are Taking: _____

CHECK SYMPTOMS YOU HAVE NOTICED SINCE ACCIDENT

❒ Headache	❒ Pins & Needles in Legs	❒ Fainting
❒ Neck Pain/stiffness	❒ Numbness in Fingers	❒ Loss of Smell
❒ Pins & Needles in Arms	❒ Numbness in Toes	❒ Loss of Taste
❒ Sleeping Problems	❒ Shortness of Breath	❒ Diarrhea
❒ Back Pain	❒ Fatigue	❒ Feet Cold
❒ Nervousness	❒ Depression	❒ Hands Cold
❒ Tension	❒ Lights Bother Eyes	❒ Stomach Upset
❒ Irritability	❒ Loss of Memory	❒ Constipation
❒ Chest Pain	❒ Ears Ring	❒ Cold Sweats
❒ Dizziness	❒ Buzzing in Ears	❒ Fever
❒ Head Seems Too Heavy	❒ Loss of Balance	❒ Face Flushed

DESCRIBE ANY OTHER SYMPTOMS NOT LISTED ABOVE:

_____

_____

_____

_____

FULL NAME: _____DOB:_____

TODAY'S DATE: _____ DATE OF ACCIDENT: _____

DESCRIBE THE ACCIDENT:

_____

_____

_____

_____

1. What was your position: ___driver ___ passenger
   *If passenger, were you in ___front seat ____right rear seat ___left rear seat
2. Were you wearing a seatbelt: ___ No ___Yes (___lap belt ___shoulder strap)
3. Did your seat have a headrest? ___ No ___ Yes (__ low __ mid __ high)
4. Did your vehicle strike a vehicle? ___ No ___ Yes
   *Did a vehicle strike you? ___ No ___ Yes
   *Did your vehicle strike any other object(s)? _____
5. Was the impact from: ___ front ___rear ___driver's side ___ passenger side
6. What was the approximate speed at the time of impact:
   *Your vehicle: _____mph
   *Other vehicle: _____mph
7. What were the road conditions: ___dry ___wet ___icy
8. At the time of impact what direction were you looking:
   ___ forward ___back ___right ___left ___up ___down
9. Were both hands on the steering wheel? ___ Yes ___ No: only ___Right ___Left
10. Was your foot on the brake? ___ No ___Yes (___ right ___ left ___both)
11. Did you brace yourself at time of impact? ___No ___Yes
12. Did the airbag(s) deploy? ___ No ____ Yes: front/side
13. Did your body strike: ___windshield ___dashboard ___ door/window
    other: _____
14. What part of the body took impact: ___chest ___head ___chin ___face ___
    knee (R/L) ___ hip/leg (R/L) ___shoulder (R/L) ___ hand (R/L) ___
    other: _____
15. Immediately after the accident, were you:
    _____ conscious _____dazed ____ unconscious

CONSENTS / ACKNOWLEDGEMENTS

- I understand that most care is given in an open adjustment office setting.
- I consent to receive communication from the office in connection with my care via postal mail, email, text, & telephone messaging. * If I withdraw my consent, I will notify the office in writing.
- A copy of the privacy policies is always available at the front desk.
- This initial visit includes a health history consultation, chiropractic exam and evaluation followed by any initial care that is determined to be clinically necessary and mutually agreed upon.
- The information I have provided on this case history form is true and accurate to the best of my knowledge.
- I give the doctors at Family Chiropractic of Chattanooga permission to render care to me today.
- I agree that I am responsible for paying for all services I receive in this office.
- If this account is placed with attorney or collections, I am responsible for all fees.
- I assign this office the rights to collect payments from all third-party payers, such as insurance & legal settlements, if arrangements are made to do so and the account is not paid in full at the time of service.
- I may request all documentation be sent on my behalf to third-party payers if available, after MMI is achieved.
- I authorize the release of my medical or other information necessary to process claims.
- The office will not enter a dispute with your insurance company; we will provide you with information needed.
- ***Missed appointments, without 24-hour notice, may be charged $15.00**
- ***PAYMENT: CASH, CHECK, or CREDIT [credit cards kept on file will be used to pay your balances due]**

LIEN: I consent to treatment as necessary or desirable to the patient first named above. I also acknowledge full responsibility for the payment of such services and agree to pay for them in full, at the time of service, unless other arrangements are made. I further agree if this account is placed in the hands of an attorney or collection agency for collections, I will be responsible for all reasonable collection/attorney fees. In such cases, I hereby assign to this office my rights to receive payments from negligent parties or from insurance companies. I hereby authorize and direct due monies to be paid directly to Family Chiropractic such sums as may be due and owing for medical service rendered me both by reason of this accident and by reason of any other bills that are due this office and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect and fully compensate said doctor.

My signature below affirms I have received/read/understand the policies for this office.

Patient's printed name: _____

Patient's Signature _____Date _____

Guardian's Signature Authorizing Care _____Date_____

Attorney's Signature _____Date _____

***Payments should be payable to and mailed to*: Family Chiropractic of Chattanooga**

6341 East Brainerd Rd, Chattanooga, TN 37421

INSURANCE / BILLING INFORMATION

If you would like us to file claims or paperwork for you at the end of your treatment for this accident, please provide a photo id and available insurance or attorney information. By providing this information, your signature gives us consent to send all records pertaining to this MVA/accident case to any/all listed below if /when records are requested:

PATIENT NAME: _____ **ACCIDENT DATE**: _____

Patient Signature: _____ Today's Date: _____

PATIENT'S AUTO INSURANCE : _____

ADDRESS: _____

PHONE: _____ FAX: _____

ADJUSTER'S NAME: _____

PHONE: _____

FAX: _____

EMAIL: _____

CLAIM # : _____

PATIENT'S ATTORNY: _____

ADDRESS: _____

_____

PHONE: _____

FAX: _____

EMAIL: _____

AT FAULT DRIVER'S NAME: _____

AT FAULT DRIVER'S INSURANCE: _____

ADDRESS: _____

PHONE: _____ FAX: _____

ADJUSTER'S NAME: _____

PHONE: _____

FAX: _____

EMAIL: _____

CLAIM # : _____