MOTOR VEHICLE COLLISION/PERSONAL INJURY QUESTIONNAIRE

Please answer all questions completely:

1. Your name and address:

   _____

   _____

   _____

2. Phone Number: _____

3. Please describe the collision in your own words:

   _____

   _____

   _____

4. Where did the collision occur? City/Town: _____ State: _____
5. Date of collision: _____ Time: _____ AM PM
6. Were you the: ☐ driver ☐ passenger ☐ pedestrian
7. If passenger, were you in the ☐ front seat ☐ right rear seat ☐ left rear seat
8. What type of vehicle were you in? _____
9. What type was the other vehicle? _____
10. Did your vehicle strike the other vehicle? ☐ yes ☐ no
11. Was your car struck by the other vehicle? ☐ yes ☐ no
12. What direction was your vehicle going? _____
13. What direction was the other vehicle going? _____
14. Was the impact from: ☐ the front ☐ the rear ☐ the left side ☐ the right side
15. What was the approximate speed at the time of the impact?

    Your vehicle _____ mph Other vehicle _____ mph
16. What was the weather at the time of the collision? ☐ dry ☐ wet ☐ icy
17. Was your vehicle in: ☐ park ☐ neutral ☐ in gear ☐moving ☐stopped
18. Were your brakes being applied? ☐ yes ☐ no
19. Was your vehicle shoved: ☐ forward ☐ backward ☐ sideways
20. Were you shoved: ☐ forward ☐ whipped backward
21. Did your seat have a head restraint (headrest?) ☐ yes ☐ no

22. If yes, what was the position ☐ low ☐ midposition ☐ high
23. Did your head ride over the headrest? ☐ yes ☐no
24. Did your hat/glasses end up in the back seat or rear window? ☐ yes ☐ no
25. Did any other part of your body hit the interior of the vehicle? ☐ yes ☐ no
26. If yes, please specify: ☐ seatbelt restraints ☐ steering wheel ☐ dashboard
    ☐ windshield ☐ side door ☐ side window ☐ other _____
27. Which part of your body? ☐ chest ☐ head ☐ chin ☐ face ☐ R L knee
    ☐ R L shoulder ☐ R L hand ☐ other _____
28. Were you holding on to the steering wheel? ☐ yes ☐ no
29. Did you brace your arms against the dash? ☐ yes ☐ no
30. Did you brace your legs against the floorboard? ☐ yes ☐ no
31. Was your ankle turned? ☐ yes ☐ no
32. Did the vehicle go into a spin or roll as a result of the impact? ☐ yes ☐ no
33. If yes, explain: _____
34. How much damage was there to the outside of the vehicle? ☐ none ☐ some ☐ a lot
35. How much damage was there to the inside of the vehicle? ☐ none ☐ some ☐ a lot
36. At the point of impact, where did you experience pain? Be specific:

    _____

    _____
37. Immediately after the accident were you: ☐ conscious ☐ dazed ☐ unconscious
38. If you lost consciousness, how long? _____
39. Were you wearing a seat belt? ☐ yes ☐ no
40. Did the belt have a shoulder harness? ☐ yes ☐ no
41. If yes, did it contribute to the pain you are experiencing? ☐ yes ☐ no
42. At the time of impact were you: ☐ looking straight ahead ☐ looking to the right
    ☐ looking to the left ☐ looking down ☐looking up
43. Did the seat break as a result of the impact? ☐ yes ☐ no
44. Were you braced for the impact? ☐ yes ☐ no
45. Were you surprised by the impact? ☐ yes ☐ no
46. Did you go to the hospital? ☐ yes ☐ no
47. If yes, when? ☐ right after the accident ☐ next day ☐ other _____

48. If yes, how did you get there? ☐ ambulance other: _____
49. If by ambulance, did the ambulance attendants place you in a: ☐ neck brace
    ☐ back brace ☐ other _____
50. Any medication or medical supplies given? _____
51. Did you have x-rays taken at the hospital? ☐ yes ☐ no
    If you went to the hospital, please answer the following:
    Name of hospital _____
    Name of doctor _____
    Diagnosis _____
    Treatment Received _____
    _____
52. Have you had any similar problems before? ☐ yes ☐ no
53. If yes, explain: _____
54. Are you diabetic? ☐ yes ☐ no
55. Do you have high blood pressure? ☐ yes ☐ no
56. Do you have low blood pressure? ☐ yes ☐ no
57. Do you have arthritis or degenerative joint disease? ☐ yes ☐ no
58. What type of work do you do? _____
59. What are your job requirements? _____
60. Have you lost any days of work from this injury? ☐ yes ☐ no
61. If yes, give dates: _____

Patient Signature _____ Date _____
Witness _____ Date _____
Print Name _____

PERSONAL INJURY INSURANCE COVERAGE

Date _____ Spoke With _____ Number _____

Patient Name _____

Insurance Company _____

Address _____

Phone Number _____

Insured Name _____

Date of Accident _____

Claim Number _____

Policy Number _____

Has the accident been reported? ☐ yes ☐ no

Name of adjuster handling claim _____

Will company accept assignment of benefits? ☐ yes ☐ no

If not, will they make checks payable to patient and our office? ☐ yes ☐ no

Limits: How much? $_____ What's left? _____

GROUP HEALTH INSURANCE

Medical benefits under auto insurance? ☐ yes ☐ no

Insurance Company _____

Address _____

Phone Number _____

Insured Name _____

Agent _____ Policy# _____ Phone _____

Name and address of other party or parties involved in collision:

_____

_____

_____

_____

ATTORNEY INFORMATION

Date _____ Spoke With _____ Number _____

Patient Name _____

Attorney Name _____

Address _____

Phone Number _____

Does attorney need copies of bills? ☐ yes ☐ no

In the event of settlement, will they protect any unpaid balance? ☐ yes ☐ no

Do they have PIP? ☐ yes ☐ no Do we file? ☐ yes ☐ no

Do they have insurance? ☐ yes ☐ no Do we file? ☐ yes ☐ no

Can we file liability? ☐ yes ☐ no

ABSOLUTE WELLNESS & REHAB OF TEXAS, P.A.
dba HIGHLAND PARK WELLNESS & REHAB
5634 DYER ST
DALLAS, TX 75206
214-219-3900/ FAX 214-219-1207

PATIENT _____

EMPLOYER _____

INSURANCE COMPANY _____

CLAIM _____ **DOI** _____

SOCIAL SECURITY NUMBER _____

ATTENTION: ATTORNEY AND/OR INSURANCE CARRIER:

ASSIGNMENT OF BENEFIT AND CAUSE OF ACTION

I HEREBY IRREVOCABLY ASSIGN AND TRANSFER AN UNDIVIDED INTEREST IN THAT PORTION OF MY CAUSE OF ACTION AND CLAIM FOR PERSONAL INJURY TO HIGHLAND PARK WELLNESS AND REHAB, AND IN ADDITION PROVIDE AN ADDITIONAL, IRREVOCABLE ASSIGNMENT OF ANY BENEFIT, PAYMENT, SETTLEMENT, CLAIM, JUDGEMENT, OR VERDICT AS A RESULT OF SAID ACCIDENT/ILLNESS, AND AUTHORIZE AND DIRECT YOU, MY ATTORNEY OR INSURANCE CARRIER, TO PAY DIRECTLY TO HIGHLAND PARK WELLNESS AND REHAB SUCH SUMS FROM SUCH PAYMENT, SETTLEMENT, CLAIM JUDGEMENT OR VERDICT AS MAY BE NECESSARY TO FULLY PROTECT SAID AMOUNT OF BILLS INCURRED AND/OR LIST HIGHLAND PARK WELLNESS AND REHAB AS AN ADDITIONAL NAMED PAYEE ON ANY SETTLEMENT CHECKS OR DRAFTS. THE UNDIVIDED INTERESTS HEREBY IRREVOCABLE ASSIGNED TO HIGHLAND PARK WELLNESS AND REHAB ARE EQUIVALENT TO THE TOTAL FOR ALL BILLS AND CHARGES FOR SERVICES PROVIDED TO ME BY HIGHLAND PARK WELLNESS AND REHAB. THE UNDIVIDED INTERESTS IRREVOCABLE ASSIGNED BY THIS AGREEMENT ARE PRESENT, NOT EXECUTORY, INTEREST.

I UNDERSTAND THAT I AM DIRECTLY AND FULLY RESPONSIBLE TO HIGHLAND PARK WELLNESS AND REHAB FOR ALL BILLS AND CHARGES FOR SERVICES RENDERED TO ME, AND THAT THIS AGREEMENT IS MADE SOLELY FOR THE ADDITIONAL PROTECTION OF AND IN CONSIDERATION OF THEIR AWAITING PAYMENT.

I FURTHER UNDERSTAND THAT SUCH PAYMENT IS NOT CONTINGENT ON ANY SETTLEMENT, CLAIM, JUDGEMENT, OR VERDICT, WHICH I MAY EVENTUALLY RECOVER. THIS AGREEMENT AND IRREVOCABLE ASSIGNMENT SUPERSEDES ANY PRIOR AGREEMENT EXECUTED BY THE UNDERSIGNED PATIENT RELATING TO THE ACCIDENT/ILLNESS REFERENCED ABOVE. IN ADDITION, THIS IRREVOCABLE ASSIGNMENT SHALL BE BINDING ON THE UNDERSIGNED ATTORNEY, AND ON ANY ADDITIONAL OR SUCCESSOR ATTORNEY I MAY ENGAGE ON MY BEHALF. UPON REQUEST BY HIGHLAND PARK WELLNESS AND REHAB, I INSTRUCT SUCH ADDITIONAL OR SUCCESSOR ATTORNEY TO ACKNOWLEDGE THIS ASSIGNMENT BY AFFIXING HIS/HER SIGNATURE HERETO. A PHOTOCOPY OF THE ASSIGNMENT SHALL BE CONSIDERED EFFECTVIE AND VALID AS THE ORIGINAL.

SIGNATURE OF POLICY HOLDER _____ DATE _____

SIGNATURE OF CLAIMANT _____ DATE _____
(IF OTHER THAN POLICY HOLDER)