

Family Chiropractic Center of Sanford

1100 Carthage Street
Sanford, North Carolina 27330
(919) 775-2114 (919) 776-4032

To All Personal Injury Patients

We will file all insurance associated with this accident, however we must have the accurate information to do so. If we do not have the accurate information, you will be responsible to pay for services at the time they are rendered. You must provide us with all insurances you wish to file within the 2 days of your initial treatment or there will be a \$5.00 charge for any additional claims.

Please provide us with the following information for each insurance company:

INSURANCE # 1:

Name of insurance co.: _____

Address of insurance co.: _____

Phone # of insurance co.: _____

Claim or Policy #: _____

Adjustor's Name: _____

INSURANCE # 2:

Name of insurance co.: _____

Address of insurance co.: _____

Phone # of insurance co.: _____

Claim or Policy #: _____

Adjustor's Name: _____

I have read and understand the above statement. I understand that I am responsible for any charges incurred at Family Chiropractic Center of Sanford. I further understand that all insurance payments will be sent to Family Chiropractic Center of Sanford, including Med Pay, and in the case of any overpayment, a refund will be issued upon settlement of my case.

Signature _____ Date _____

Witness _____

D. HOSPITAL VISIT AFTER ACCIDENT / INJURY

3. If a CAT Scan was performed, of what body part(s)?

- Head Upper / Mid Back Chest / Rib Cage
 Neck Lower Back Abdomen
 Other _____

4. If a MRI was performed, of what body part(s)?

- Head Upper / Mid Back Chest / Rib Cage
 Neck Lower Back Abdomen
 Other _____

5. What was the diagnosis given at the hospital?

a. Head

- Concussion Skull Fracture Lacerations
 Contusions Other _____

b. Jaw

- Strain Sprain Dislocation
 Fracture Whiplash Lacerations
 Contusions Other _____

c. Neck

- Strain Sprain Dislocation
 Fracture Whiplash Disc Injury
 Lacerations Contusions
 Other _____

d. Upper / Middle Back

- Strain Sprain Dislocation
 Fracture Disc Injury Lacerations
 Contusions Other _____

e. Lower Back

- Strain Sprain Dislocation
 Fracture Disc Injury Lacerations
 Contusions Other _____

f. Pelvis

- Strain Sprain Dislocation
 Fracture Lacerations Contusions
 Other _____

g. Chest / Rib Cage

- Strain Sprain Dislocation
 Fracture Lacerations Contusions
 Other _____

h. Abdomen

- Strain Lacerations Contusions
 Other _____

i. Shoulders

- Strain Sprain Dislocation
 Fracture Lacerations Contusions
 Other _____

j. Arms

- Strain Sprain Dislocation
 Fracture Lacerations Contusions
 Other _____

k. Elbows

- Strain Sprain Dislocation
 Fracture Lacerations Contusions
 Other _____

l. Forearms

- Strain Sprain Dislocation
 Fracture Lacerations Contusions
 Other _____

m. Wrists

- Strain Sprain Dislocation
 Fracture Lacerations Contusions
 Other _____

n. Hands / Fingers

- Strain Sprain Dislocation
 Fracture Lacerations Contusions
 Other _____

o. Buttocks

- Strain Sprain Lacerations
 Contusions Other _____

p. Hips

- Strain Sprain Dislocation
 Fracture Lacerations Contusions
 Other _____

q. Thighs

- Strain Sprain Dislocation
 Fracture Lacerations Contusions
 Other _____

r. Knees

- Strain Sprain Dislocation
 Fracture Lacerations Contusions
 Other _____

s. Legs

- Strain Sprain Dislocation
 Fracture Lacerations Contusions
 Other _____

t. Ankles

- Strain Sprain Dislocation
 Fracture Lacerations Contusions
 Other _____

u. Feet / Toes

- Strain Sprain Dislocation
 Fracture Lacerations Contusions
 Other _____

v. Other

- Strain Sprain Dislocation
 Fracture Lacerations Contusions

w. Describe any additional diagnosis given:

D. HOSPITAL VISIT AFTER ACCIDENT / INJURY

6. What treatment was administered at the hospital?

- Oral Medication Sutures Splint Collar
- Injection Ice Packs Cast Support
- Topical Antiseptics Hot Packs Brace Surgery
- Bandages Other _____

7. Instructions Given When Discharged From Hospital

a. Were you told to see?

- General Practitioner Chiropractor Neurologist
- Physical Therapist Orthopedist Internist
- General Surgeon Plastic Surgeon
- Other _____

b. What recommendations were made?

- No Further Care No Follow-up Instructions Observation
- Rest Ice Heat Collar Support
- Time Off Work Other _____

c. Were medications prescribed?

- Pain Anti-inflammatory Antibiotic Nervousness
- Other _____

E. FOLLOWING THE ACCIDENT / INJURY

1. How much later did additional symptoms develop?

- Immediately Hours That Evening Next Morning
- Days Week Month _____

2. What additional symptoms developed?

a. Head

- Pain Stiffness Numbness Tingling
- Other _____

b. Jaw

- Pain Stiffness Numbness Tingling
- Other _____

c. Neck

- Pain Stiffness Numbness Tingling
- Other _____

d. Upper / Middle Back

- Pain Stiffness Numbness Tingling
- Other _____

e. Lower Back

- Pain Stiffness Numbness Tingling
- Other _____

f. Pelvis

- Pain Stiffness Numbness Tingling
- Other _____

g. Chest / Rib Cage

- Pain Stiffness Numbness Tingling
- Other _____

h. Abdomen

- Pain Stiffness Numbness Tingling
- Other _____

i. Shoulders

- Pain Stiffness Numbness Tingling
- Other _____

j. Arms

- Pain Stiffness Numbness Tingling
- Other _____

k. Elbows

- Pain Stiffness Numbness Tingling
- Other _____

l. Forearms

- Pain Stiffness Numbness Tingling
- Other _____

m. Wrists

- Pain Stiffness Numbness Tingling
- Other _____

n. Hands / Fingers

- Pain Stiffness Numbness Tingling
- Other _____

o. Buttocks

- Pain Stiffness Numbness Tingling
- Other _____

p. Hips

- Pain Stiffness Numbness Tingling
- Other _____

q. Thighs

- Pain Stiffness Numbness Tingling
- Other _____

r. Knees

- Pain Stiffness Numbness Tingling
- Other _____

s. Legs

- Pain Stiffness Numbness Tingling
- Other _____

t. Ankles

- Pain Stiffness Numbness Tingling
- Other _____

u. Feet / Toes

- Pain Stiffness Numbness Tingling
- Other _____

v. Other

3. Since your accident / injury have you suffered from?

- Blurred Vision Chest Pain Nausea
- Double Vision Difficulty Breathing Vomiting
- Reduced Vision Palpitations Frequent Urination
- Impaired Hearing Constipation Inability To Hold Urine
- Ringing In Ears Diarrhea Painful Urination

D. AT MOMENT OF IMPACT

1. Were you prepared for the accident?

- Accident A Complete Surprise
- Aware Of Impending Collision
- And Braced For Impact

2. Foot On Brake Pedal

a. Was your foot on brake pedal at impact? Yes No

b. Was it knocked off pedal by impact? Yes No

3. Use Of Restraints

a. Restraint Belts

1. Were you wearing a restraint belt? Yes No

2. What type of restraint belt were you wearing?

- Shoulder-Lap Belt
- Shoulder Belt
- Lap Belt

b. Headrests

1. Was vehicle equipped with headrests? Yes No

2. What position was the headrest in?

- Low
- Middle
- High
- Don't Know

c. Air Bags

1. Was vehicle equipped with air bags?

- Yes
- No
- Unsure

2. Did the air bags deploy? Yes No

4. Your Body

a. What was your body position at impact?

- Straight
- Slouched Forward
- Rotated:** Right Left
- Don't Recall
- Other

b. What direction was your body thrown?

- Forward\Backward
- Backward\Forward
- Sideways
- Across Vehicle
- Outside Vehicle
- Under Vehicle
- Don't Recall
- Other

5. Your Head And Neck

a. What position were your head/neck in at impact?

- Straight
- Tilted Forward
- Rotated:** Right Left
- Don't Recall
- Other

b. Through what motion were your head/neck pitched?

- Forward\Backward
- Backward\Forward
- Sideways
- Don't Recall
- Other

E. RESULT OF IMPACT

1. Which objects in the vehicle did the force of the collision cause your body to strike?

a. Head

- Steering Wheel
- Dashboard
- Windshield
- Right Side Door
- Left Side Door
- Armrest
- Right Window
- Left Window
- Headrest
- Ceiling
- Console
- Shift Lever
- Front Seat
- Rear View Mirror
- Other

b. Right Upper Extremity (Arm)

- Steering Wheel
- Dashboard
- Windshield
- Right Side Door
- Left Side Door
- Armrest
- Right Window
- Left Window
- Headrest
- Ceiling
- Console
- Shift Lever
- Front Seat
- Rear View Mirror
- Other

c. Left Upper Extremity (Arm)

- Steering Wheel
- Dashboard
- Windshield
- Right Side Door
- Left Side Door
- Armrest
- Right Window
- Left Window
- Headrest
- Ceiling
- Console
- Shift Lever
- Front Seat
- Rear View Mirror
- Other

d. Torso

- Steering Wheel
- Dashboard
- Windshield
- Right Side Door
- Left Side Door
- Armrest
- Right Window
- Left Window
- Headrest
- Ceiling
- Console
- Shift Lever
- Front Seat
- Rear View Mirror
- Other

e. Right Lower Extremity (Leg)

- Steering Wheel
- Dashboard
- Windshield
- Right Side Door
- Left Side Door
- Armrest
- Right Window
- Left Window
- Headrest
- Ceiling
- Console
- Shift Lever
- Front Seat
- Rear View Mirror
- Other

f. Left Lower Extremity (Leg)

- Steering Wheel
- Dashboard
- Windshield
- Right Side Door
- Left Side Door
- Armrest
- Right Window
- Left Window
- Headrest
- Ceiling
- Console
- Shift Lever
- Front Seat
- Rear View Mirror
- Other

2. Did your body strike any other objects?

Description Of Other Objects Your Body Hit:

F. ADDITIONAL INFORMATION

Additional Information About Your Automobile Accident:

Patient's Or Guardian Signature:

Date:

