

Bartz Chiropractic
814 Pine Island Road, Suite 306
Cape Coral, FL 33991

Auto Accident History

Date _____

Name _____
 First **Middle** **Last**

Address _____

City _____ **State** _____ **Zip** _____

Soc Sec # _____ **Home Phone** _____

Birthdate _____ **Age** _____ **Gender: M F**

Marital Status: M S W D **Number of Children** _____

ATTORNEY INFORMATION	
Name _____	_____
Address _____	_____
_____	_____
Work Phone _____	_____

AUTO ACCIDENT INFORMATION

Date of Accident: _____ **Time of Accident:** _____

In your own words, please describe how accident happened: _____

In your own words, please describe injury received and to what parts of body: _____

What type of car were you in? _____

What type of car was other driver in? _____

Were you: () Driver () Passenger () Front Seat () Back Seat

Where you wearing your seatbelt? () Yes () No

Does your car have airbags? () Yes () No If yes, did they inflate? () Yes () No

Approximate speed of vehicle at time of accident: _____

Number of people in your vehicle? _____ Other Vehicle? _____

Were you struck from: () Behind () Front () Left side () Right side

What direction were you headed? () North () East () South () West
on (name of street) _____

What direction was the other vehicle headed? () North () East () South () West

on (name of street) _____

Were you knocked unconscious? () Yes () No. If yes, for how long? _____

Did any part of your body strike anything in vehicle? () Yes () No

If yes, please describe: _____

Was there damage to your car? () Minor () Moderate () Extensive () Totaled

Was the accident? () Complete Surprise () Saw car coming (able to brace body for impact)

Position of body at impact: () Straight Ahead () Slouched () Rotated Left () Rotated Right

Were police notified? () Yes () No

Was a police report filed? () Yes () No

Was a traffic violation issued () Yes () No If so, to whom? _____

Please describe how you felt:

a. DURING the accident: _____

b. IMMEDIATELY AFTER the accident: _____

c. LATER THAT DAY _____

d. THE NEXT DAY: _____

Where were you taken after the accident? _____

How long after the accident did you go? _____

Have you ever been treated by a hospital or another doctor since the accident? () Yes () No.

If yes, please list doctor's name and address: _____

What type of treatment did you receive? _____

What recommendations were made? _____

Since this injury occurred, are your symptoms: () Improving () Getting Worse () Same

Home care how you treat symptoms: _____

CHECK SYMPTOMS YOU HAVE NOTICED SINCE ACCIDENT:

- | | | | | | |
|-------------|---------------------|------------------------|---------------------|--------------------|---------------|
| Headache | Irritability | Numbness in Toes | Face Flushed | Feet Cold | Neck Pain |
| Chest Pain | Shortness of Breath | Buzzing in Ears | Hands Cold | Neck Stiff | Dizziness |
| Fatigue | Loss of Balance | Stomach Upset | Sleeping Problems | Heavy Head Feeling | Depression |
| Fainting | Constipation | Back Pain | Pins & Needles Arms | Lights Bother Eyes | Loss of Smell |
| Cold Sweats | Nervousness | Pins & Needles in Legs | Loss of Memory | Loss of Taste | Fever |
| Tension | Numbness in Fingers | Ears Ring | Diarrhea | Other (add below) | |

Symptoms Other Than Above: _____

What are your PRESENT complaints and symptoms? _____

Do you have any previous illnesses which relate to this case? _____ () Yes () No

If yes, please describe: _____

Did you have any physical complaints BEFORE THE ACCIDENT? () Yes () No

If yes, please describe in detail: _____

Have you ever been involved in an accident before? () Yes () No.

If yes, please describe, including date(s) and type(s) of accidents, as well as injuries received. _____

Have you lost time from work as a result of this accident? () Yes () No (If yes, please complete below)

a. Last Day Worked: _____

b. Type of Employment: _____

c. Are you being compensated for time lost from work? () Yes () No. (If yes, please complete below)

Type of compensation you are receiving? _____

Do you notice any activity restrictions as a result of this injury?() Yes () No (If yes, please complete below) _____

Other pertinent information: _____

Have you contacted an adjuster regarding this claim?

Company: _____

Address: _____ Phone # _____

Adjuster: _____ Claim#: _____

ASSIGNMENT OF BENEFITS

I, _____, hereinafter ASSIGNOR, hereby authorize
(Name of insured patient)

_____ to pay directly to **Bartz Chiropractic, LLC**
(Name of Insurance Carrier) (Name of Medical Provider)

hereinafter ASSIGNEE, the medical benefits other wise payable to me for their services, but not to exceed the charges of those services. I hereby ASSIGN to ASSIGNEE any benefits or causes of action under any policy of insurance, indemnity agreement, or any other collateral source as defined in Florida Statutes for any service and or charges provided by ASSIGNEE. This ASSIGNMENT OF BENEFITS is given in exchange for ASSIGNEE agreeing to send request for payment to the above named insurance carrier for all payments due and payable pursuant to the ASSIGNOR’S contract of insurance. This ASSIGNMENT OF BENEFITS is IRREVOCABLE unless subsequent revocation is in writing and agreed to by both parties.

MEDICAL RELEASE

This document shall be sufficient to authorize any person having records of medical treatment, services, or supplies pertaining to me, to release true copies of same to ASSIGNEE or any insurer providing coverage to me in connection with the processing of any claim for benefits made by the ASSIGNEE herein. A photocopy of this document shall be as binding as an original signature page.

IN WITNESS WHERE OF the undersigned ASSIGNOR and ASSIGNEE have hereunto set their hands, this
_____ day of _____, 20__ .

Patient’s Signature (ASSIGNOR)

Authorized Representative of ASSIGNEE

Patient’s Name (Please Print Clearly)

Auto Accidents:

I authorize the release of PIP/Med. payment records to Bartz Chiropractic, LLC.

I authorize Bartz Chiropractic, LLC the right to obtain my Declaration Page of my Auto Policy.

Patient Name (Please Print Clearly)

Patient/Guardian Signature

Date