ACCIDENT / INJURY FORM

NAME_____ **TODAY'S DATE**_____

Date of Accident _____ Time: ___ am ___ pm Location of Accident _____

AUTO INJURY

Were You: ( ) Driver ( ) Passenger ( ) Pedestrian

Were you struck: ( ) From Behind ( ) On Passenger Side ( ) On Driver's Side ( ) Head On ( ) While Parked

Were you wearing your seatbelt? ( ) Yes ( ) No Did any airbags deploy? ( ) Yes ( ) No

What was the speed of your vehicle? _____ Speed of opposing vehicle? _____

Did your car strike the others involved: ( ) Yes ( ) No ( ) Undetermined

Did the other car strike yours: ( ) Yes ( ) No ( ) Undetermined

As a result of the Accident, were traffic citations issued to you? ( ) Yes ( ) No

BODY PARTS STRUCK (example: head hit dash, etc.)

Please explain: _____

ON-THE-JOB INJURY

How did the injury occur? _____

Did you report the injury to your foreman or employer: ( ) Yes ( ) No

Employer: _____ Address: _____

OTHER

Describe the circumstances of the accident (Be Specific) _____

_____

CHECK SYMPTOMS THAT YOU HAVE NOTICED SINCE THE ACCIDENT

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

ADDITIONAL ACCIDENT DETAILS

Discomfort was noticed: ( ) Immediately ( ) Later that day ( ) The next day ( ) Other: _____

Have you lost any days of work? ( ) Yes ( ) No If Yes, _____ through _____

DID YOU GO TO THE EMERGENCY ROOM? ( ) Yes ( ) No

If yes, did you go: ( ) Immediately ( ) Later that day ( ) The next day ( ) Other: _____

If yes, were you taken by: ( ) Ambulance ( ) Private Transportation

Which hospital which hospital were you taken to? _____

What tests were done? ( ) X-rays ( ) CT scan ( ) MRI ( ) Ultrasound ( ) Other: _____

Where you given medications/prescriptions: ( ) Yes ( ) No

If so, what medications/prescriptions were you given? _____

Where you given: ( ) Crutches ( ) Bandages ( ) Stitches ( ) Other: _____

PERSONAL INJURY & WORKER'S COMPENSATION INSURANCE INFORMATION

Patient Name: _____ Today's Date: _____ Accident Date: _____

PERSONAL INJURY / CAR ACCIDENT

Have you filed a claim with YOUR insurance company? ( ) Yes ( ) No

Patient's Auto Insurance Company: _____ **Insurance Phone**: _____

Claims Mailing Address (NOT AGENTS ADDRESS): _____

City: _____ State: _____ Zip: _____ **Claim #:** _____

Name of Insurance Adjuster: _____ **Adjuster Phone:** _____

Third Party Insurance (Insurance from other car involved, if any): _____

Claims Mailing Address (NOT AGENTS ADDRESS): _____

City: _____ State: _____ Zip: _____ **Phone:** _____ **Claim #:** _____

Attorney: _____ Address: _____

City: _____ State: _____ Zip: _____ **Attorney Phone #:** _____

WORKER'S COMPENSATION / WORK INJURY

Employer Name: _____ **Supervisor Name:** _____

Employer Address: _____**Employer Phone**: _____

Employer Insurance Contact: _____ **Contact Phone:** _____

---------- **OFFICE USE ONLY** ----------

Have you contacted the Insurance Adjuster? ( ) Yes ( ) No Med Pay Limit: _____

Have you contacted the Attorney? ( ) Yes ( ) No Will the attorney protect the doctor? ( ) Yes ( ) No

Has Employer been contacted? ( ) Yes ( ) No

Does Employer hold Worker's Comp Insurance or do they handle their own claims? _____

Notes: _____

_____

Hall Chiropractic Pain Relief Center

Dr. Robert E. Hall
CHIROPRACTIC PHYSICIAN

801 Glen Park Avenue
Griffith, IN 46319
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www.drroberthall.com

DOCTOR'S LIEN

To whom it may concern:

I hereby authorize and direct you, my insurance company and/or my attorney, to pay directly to Dr. Robert Hall such sums as may be due and owing this office for services rendered to me, both by reason of accident or illness, and by reasons of any other bills that are due this office and to withhold such sums from any disability benefits, medical payments, benefits, health and accident benefits, worker's compensation benefits or any other insurance benefits, obligated to reimburse me from any settlement, judgement or verdict on my behalf as may be necessary to adequately protect said Dr. Robert Hall. I hereby further give to said office, against any and all insurance benefits named herein, and any and all proceeds of any settlement, judgement or verdict which I have been treated by said office. This is to act as an assignment of my rights and benefits to the extent of Dr. Hall's services provided.

In the event my insurance company, obligated to make payment to me upon the charges made by this office for their services, refused to make such payments, upon demand of action that might exist in my favor against such company.

I understand that I remain personally responsible for the total amount due to Dr. Robert Hall for his services. I further understand and agree that this Assignment, await payments and they may demand payments from me immediately upon rendering services at their option.

I authorize Dr. Robert Hall to release any information pertinent to my case to any insurance company, adjuster or attorney to facilitate collection under this Assignment, Lien and Authorization.

Patient Signature: _____ Date:_____

Witness Signature: _____Date: _____