Please provide us with the following personal and other pertinent information requested.

Today's date ______________________

Name ______________________ Nick-name preferred: ______________________

Date of Birth ______________________ ☐ Male ☐ Female Soc.Sec # ______________________

Mailing Address ______________________

City, State, Zip ______________________ Home Phone ______________________

Occupation ______________________

Employer ______________________ Work Phone ______________________

Employer's Address : ______________________

City, St, Zip ______________________

Were you referred by ☐ Yourself ☐ Friend ☐ Insurance Carrier ☐ Primary physician ☐ Other physician

FINANCIAL :	YOUR AUTO INSURANCE CARRIER	YOUR MAJOR MEDICAL CARRIER
NAME		
ADDRESS		
CITY,ST.ZIP		
POLICY #		
INSURED NAME		

OTHER FINANCIAL	OTHER DRIVERS INSURANCE CARRIER	YOUR ATTORNEY
NAME		
ADDRESS		
CITY,ST.ZIP		
POLICY #		Telephone #
INSURED NAME		Fax #

Please describe the accident in your own words:

____

____

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I the undersigned hereby authorize the staff to perform such services as deemed necessary by the physician to diagnose and treat my condition(s). Further I authorize assignment of my insurance rights and benefits directly to this provider and also authorize the release of such information as is needed to process insurance claims. I understand that I am responsible for all charges which may include legal fee, collection fees or other expenses incurred by the provider in collecting my account. I hereby order all parties to accept a copy of this release and assignment in lieu of the original. This shall remain in effect until revoked by me in writing.

______________________ ______________________
Signature Date

AUTO ACCIDENT SUPPLEMENT

DATE OF ACCIDENT: TIME OF ACCIDENT: WAS A POLICE REPORT FILED [ ] NO [ ] YES [AR#

INVOLVING: [ ] CAR [ ] TAXI [ ] VAN [ ] TRUCK WERE YOU [ ] DRIVER [ ] PASSENGER [ ] Front [ ] Back
[ ] MOTORCYCLE [ ] BUS [ ] OTHER ________________ [ ] PEDESTRIAN [ ] RIDING A BICYCLE

WERE YOU STRUCK FROM [ ] FRONT [ ] BEHIND [ ] LEFT [ ] RIGHT [ ] LEFT OBLIQUE [ ]RIGHT OBLIQUE

DID YOU STRIKE [ ] WINDOW [ ] DOOR [ ] DASH [ ] STEERING WHEEL WERE YOU WEARING A SEAT BELT? YES [ ] NO [ ]

DID YOU HIT YOUR HEAD ? [ ] NO [ ] YES DID YOU LOOSE CONSCIOUSNESS ? [ ] NO [ ] YES HOW LONG ________________

WERE YOU TAKEN TO THE HOSPITAL [ ] NO [ ] YES [ ] BY AMBULANCE [ ] BY RELATIVE [ ] DROVE MYSELF [ ] NEXT DAY

NAME OF HOSPITAL and ADDRESS:

WERE YOU? (PLEASE CHECK ALL THAT APPLY

[ ] KEPT OVERNIGHT [ ] ADMITTED FOR _____ DAYS
[ ] X-RAYED [ ] TREATED CUTS / BRUISES
[ ] TREATED FOR FRACTURES [ ] EXAMINED AND RELEASED
[ ] EXAMINED AND RELEASED WITH MEDICATION
[ ] ADVISED TO FOLLOW UP WITH MY OWN PHYSICIAN ON NEXT DAY

What problems are you having today?

HAVE YOU EVER BEEN IN AN ACCIDENT BEFORE [ ] NO [ ] YES

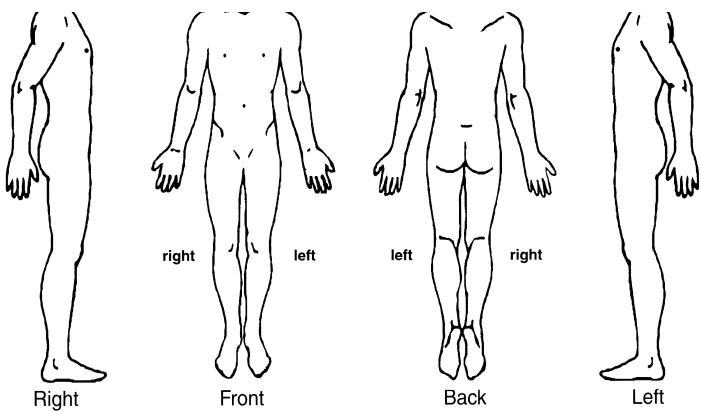
WHEN/WHERE

ON THE FIGURES AT THE RIGHT, PLEASE MARK YOUR AREA(S) OF PAIN OR DISCOMFORT.

+++	Burning	///	Stabbing
....	Pins & needles	XXX	No feeling

Circle the areas (if more than one) of pain and tell us on a scale of 1 to 10, with 1 being light pain to 10 being very severe, how severe is your pain in each area most of the time.

AREA 1 pain is (1-10) ___________



Which words describes your pain MOST of the time?

[ ] Constant [ ] Tingling
[ ] On and Off [ ] Burning
[ ] Occasional [ ] Throbbing
[ ] Only at night [ ] Deep, stabbing
[ ] Only on exertion [ ] Deep Achy
[ ] Dull Ache [ ] Sharp recurring pain

How would you describe your current mobility?

[ ] Self Mobile [ ] Need Walker
[ ] Need Cane [ ] Need Wheelchair

Which best describes your current employment?

[ ] Working [ ] full time [ ] Part time
[ ] Unemployed
[ ] On sick leave
[ ] On temporary disability
[ ] On permanent disability
[ ] Retired

If on temporary or permanent disability or sick leave,
Last full day of work was ______________________

			Auto Accident Supplement
PATIENT	ID#	DATE	