Vehicle Accident Information Form

Patient Name: _____

1. What was the date of the accident? _____
2. Approximately what time did the accident occur? _____:_____AM / PM
3. How many vehicles were involved in the accident? _____
4. What was the estimated damage to the vehicle you were in? _____
5. What street were you on when the accident occurred? _____
6. What direction were you traveling in? _____
7. What city did the accident occur in? _____
8. What state did the accident occur in? _____
9. What type of impact was the auto accident? _____
10. Did your vehicle hit anything after the accident (i.e. tree or guard rail)? If yes, please describe

_____

11. Where were you sitting in the vehicle during the accident? _____
12. Did you know the accident was coming? _____
13. What type of vehicle were you in? _____
14. What type of vehicle impacted yours? _____
15. At the time of the impact you were:
    - -Slowing down
    - -Stopped
    - -Gaining Speed
    - -Moving at a steady speed
16. At the time of the impact, approximately how fast was your vehicle moving? _____MPH
17. At the time of the impact was the other car was:
    - -Slowing down
    - -Stopped
    - -Gaining Speed
    - -Moving at a steady speed
18. At the time of impact, approximately how fast was the other vehicle moving? _____MPH

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19. During and after the crash what happened to your vehicle? (Please circle all that apply)
    - kept going straight
    - kept going straight hitting a car in front
    - was hit by another vehicle
    - spun around
    - spun around and hit a stationary object
    - hit a stationary object

20. Did you lose consciousness during the accident? Yes / No

21. How was your head positioned during the accident? _____

22. How was your torso positioned during the accident? _____

23. How were your hands positioned during the accident? _____

24. Did your head hit anything during the accident? No / Yes, please describe _____

25. Did your face hit anything during the accident? No / Yes, please describe _____

26. Did your shoulders hit anything during the accident? No / Yes, please describe _____

27. Did your neck hit anything during the accident? No / Yes, please describe _____

28. Did your chest hit anything during the accident? No / Yes, please describe _____

29. Did your hips hit anything during the accident? No / Yes, please describe _____

30. Did your knees hit anything during the accident? No / Yes, please describe _____

31. Did your feet hit anything during the accident? No / Yes, please describe _____

32. What kind of headrest was in your vehicle?
    - movable fixed headrest
    - non-movable fixed headrest
    - no headrest

33. Where was the headrest positioned on your head? (Please circle which applies best)
    - at the top of the back of your head
    - at the middle height of the back of your head
    - at the lower portion of the back of your head
    - at level with the back of your neck
    - at the level of your shoulder blades

34. Did you have your seatbelt on during the accident? -Yes -No

35. Did you slide out of your seatbelt during the accident? _____

36. What was damaged in your vehicle? (Please circle all that apply)
    - windshield
    - steering wheel
    - dashboard
    - seat frame
    - side window
    - completely totaled
    - rear window
    - mirror
    - knee bolster
    - rear bumper
    - front bumper
    - other: _____
    - trunk
    - front left door
    - front right door
    - back left door
    - back right door

37. Choose the items that dented inward:

- floorboards - side door - dashboard

38. Choose the doors that would not open as a result of the accident:
    - front left - rear left - front right - rear right

39. Did you go to the hospital? If no, why and do not answer 40-47 _____

40. How did you get to the hospital? _____

41. What was the name of the hospital? _____

42. Were you hospitalized over night? _____

43. Circle what you were prescribed at the hospital (if applicable):

    Pain Medication Muscle Relaxers Not Applicable

44. Did you receive any stitches for any cuts at the hospital? If yes, which area(s) of the body?

_____

45. Did you receive any of the following at the hospital?

    Neck Brace Back Brace Not Applicable

46. Were x-rays taken at the hospital? If yes, which area(s) of the body were they taken?

_____

47. Was an MRI/CT Scan taken at the hospital? If yes, which area(s) of the body were they taken?

_____

Patient/Guardian Signature_____ **Date:** _____

CORE PHYSICAL MEDICINE

ASSIGNMENT OF BENEFITS

Patient hereby irrevocably acknowledges full financial responsibility for all services provided to patient by Core Physical Medicine (Provider), as consideration for such Provider services. Patient irrevocably assigns to Core Physical Medicine (Provider), any and all benefits payable by or from any insurance or health care plan(s) coverage maintained by Patient as consideration for the total fee for those charges incurred by Patient as a result of those services rendered by Provider. Patient also assigns to Core Physical Medicine (Provider): (i) any and all benefits payable by or from any automobile medical payment coverage maintained by Patient or any party under whose policy of insurance Patient may have a lawful right of recovery, (ii) any and all benefits payable by or under any third party liability insurance coverage to which Patient may have a right of recovery due to the injuries for which Patient has sought Provider's health care services, and (iii) a "common law lien interest" in, and all contractual rights and claims to, any and all future insurance proceeds Patient has against any insurance company, health care benefit plan, or any other party contractually liable to Patient for payment of all or any portion of the health care services rendered by Core Physical Medicine (Provider), and the resultant charges therefore, to the Patient as a result of the injuries sustained by Patient. This irrevocable Assignment of Benefits, conveyance of lien interest and contractual rights to and for those charges attributable to Core Physical Medicine's (Provider) health care services shall extend to, but not be limited to, Provider's entitlement to any and all insurance proceeds remitted as a result of any insurance claim for damages by the Patient which has given rise to the above referenced health care services provider by Core Physical Medicine (Provider).

By my signature be it know that I have read and fully understand the above contract.

Patient Name_____(Print)_____

Custodian Parent/Legal Guardian_____(Print)_____

Witness_____(Print)_____

Date_____