

FAMILY CHIROPRACTIC

Welcome to Family Chiropractic

Automobile Accident Questionnaire

Today's Date _____
Last Name _____ First Name _____ MI _____
Street _____ City _____ State _____ Zip _____
Date of Birth _____ Sex _____ Marital Status _____
SS# _____ Phone # _____ Cell Phone # _____
E-mail Address _____
Employer _____ Occupation _____
Employer Street _____ City _____ State _____ Zip _____
How did you hear about us? _____

Accident Information

Date of Accident _____ Time of Accident _____ Reported to Police? Y / N
Did you report the accident to your Insurance Company? Y / N To whom? _____
Your Insurance Company _____ Phone _____
Street _____ City _____ State _____ Zip _____
Agent/Adjuster _____ Phone _____
Policy# _____ Claim# _____ File# _____
Name of Policyholder _____ Your Relationship to Holder _____
Did you submit the "Application of No-Fault Benefits" form to your insurance? Y / N
*This is a required document so if you do not think you have filled this out please notify the front desk.
When did your present symptoms appear? _____
Have you ever had complaints in the involved area before? Y / N If Yes, Explain: _____

Since the accident, are your symptoms: ___ Improving ___ Getting Worse ___ Stayed the same
Please indicate your level of pain (1=mild, 10=severe): 1 2 3 4 5 6 7 8 9 10
Have you missed any work? Y / N When? ____/____/____ to ____/____/____
Have you retained an attorney? Y / N Who? _____
Street _____ City _____ State _____ Zip _____
In case of an Emergency who should be notified? _____
Relationship to you? _____ Phone # _____

Privacy: In Accordance with your right to privacy, we will not discuss any of your personal information or treatment information with anyone other than yourself, other treating providers or your insurance company. It is customary to leave voice messages regarding appointment dates and times or to request return calls.

I have read and understand all above information; all information I have provided is true to the best of my knowledge. I also understand that I am personally responsible for payment in the event that my claim for No-Fault is denied.

Signature _____ Date _____

Auto Accident Form

Patient Name _____

Today's Date ____/____/____

Date of Accident ____/____/____

Please mark your involvement in the Auto Accident: Pedestrian Driver Passenger

What are your current symptoms? Pain Numbness Stiffness Weakness Dizziness

Patient was located: Driver Passenger- middle front Passenger- right front
 Passenger- left rear Passenger- middle rear Passenger- right rear

Patient Vehicle Type: Compact Mid-size Full-Size SUV Pick-up Motorcycle

Second Vehicle Type: Compact Mid-size Full-Size SUV Pick-up Motorcycle

Third Vehicle Type: Compact Mid-size Full-Size SUV Pick-up Motorcycle

Road Conditions: Clear Dark Dry Foggy Icy Wet

Road Type: Asphalt Concrete Dirt Gravel

Were you aware the accident was going to occur? Yes No

Were you wearing a seatbelt? Yes No

Did your airbag deploy? Yes No

Does your car have a head rest? Yes No

What position was the head rest in? Up Middle Down

Patient's Head Position: Looking Straight Ahead Left Level Left Up Left Down
 Right Level Right Up Right Down Looking Up Looking Down

Accident Details

Was your car braking? Yes No Was your car moving? Yes No

If yes, how fast? (mph) <5 6-10 11-15 16-20 21-30 31-40 41-50 51-60 61-70 >70

Was the second vehicle braking? Yes No Was the second vehicle moving? Yes No

If yes, how fast? (mph) <5 6-10 11-15 16-20 21-30 31-40 41-50 51-60 61-70 >70

Was the third vehicle braking? Yes No Was the third vehicle moving? Yes No

If yes, how fast? (mph) <5 6-10 11-15 16-20 21-30 31-40 41-50 51-60 61-70 >70

Family Chiropractic

Dr. John Przybylak • Dr. Jessica D'Amore-Przybylak • 4017 Harlem Rd • Snyder, NY 14226 • 716.839.5100

Collision Details

First Impact: hit by other vehicle hit other vehicle hit by object hit object
Impact Location: front front-right front-left left
 right right-rear left-rear rear top

Second Impact: hit by other vehicle hit other vehicle hit by object hit object
Impact Location: front front-right front-left left
 right right-rear left-rear rear top

Collision Results

Body was thrown: Forward Backward Left Right Can't Remember

Head Hit: airbag front windshield rearview mirror steering wheel
 dashboard back of the front seat side window/door another person's body headrest

Chest Hit: airbag steering wheel dashboard back of the front seat
 side window/door another person's body

Shoulders Hit: shoulder harness side window/door back of front seat another person's body

Knees Hit: steering wheel dashboard back of the front seat
 door panel center console another person's body

Hips Hit: steering wheel dashboard back of the front seat
 door panel center console another person's body

Hospitalized

Were you hospitalized? Yes Where? _____ No

If yes, please answer the questions below.

When were you hospitalized? immediately later same day next day date _____

How were you transported to the hospital? ambulance life flight private transportation

What did the hospital recommend? no instructions see this clinic see DC (Chiropractor)
 see primary doctor see orthopedist see neurologist prescription medication
 other: _____

Did you have any x-rays taken? Yes No

If yes, what areas? _____

Patient's Name _____ **Patient's Signature** _____

**NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW
ASSIGNMENT OF BENEFITS FORM**

(FOR ACCIDENTS OCCURRING ON AND AFTER 3/1/02)

I, _____, ("Assignor") hereby assign to _____, ("Assignee")
(Print patient's name) (Print hospital or health care provider name)
all rights privileges and remedies to payment for health care services provided by assignee to which I am entitled under Article 51 (the No-Fault statute) of the Insurance Law.

The Assignee hereby certifies that they have not received any payment from or on behalf of the Assignor and shall not pursue payment directly from the Assignor for services provided by said Assignee for injuries sustained due to the motor vehicle accident which occurred on _____, not withstanding any other agreement to the contrary.
(Print accident date)

This agreement may be revoked by the assignee when benefits are not payable based upon the assignor's lack of coverage and/or violation of a policy condition due to the actions or conduct of the assignor.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR COMMERCIAL INSURANCE OR A STATEMENT OF CLAIM FOR ANY COMMERCIAL OR PERSONAL INSURANCE BENEFITS CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, AND ANY PERSON WHO, IN CONNECTION WITH SUCH APPLICATION OR CLAIM, KNOWINGLY MAKES OR KNOWINGLY ASSISTS, ABETS, SOLICITS OR CONSPIRES WITH ANOTHER TO MAKE A FALSE REPORT OF THE THEFT, DESTRUCTION, DAMAGE OR CONVERSION OF ANY MOTOR VEHICLE TO A LAW ENFORCEMENT AGENCY, THE DEPARTMENT OF MOTOR VEHICLES OR AN INSURANCE COMPANY, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE VALUE OF THE SUBJECT MOTOR VEHICLE OR STATED CLAIM FOR EACH VIOLATION.

(Print name of Patient)

(Signature of Patient)

(Date of signature)

(Address of Patient)

(Print name of Provider)

(Signature of Provider)

(Date of signature)

(Address of Provider)

FAMILY CHIROPRACTIC

Terms of Acceptance

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of focus to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental and social well-being, not merely the absence of infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I, _____ have read and fully understand the above statements.
(print name)

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis.

(signature)

(date)

Consent to evaluate and adjust a **minor child**

I, _____ being the parent or legal guardian of

_____ have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

Pregnancy Release

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child. Date of last menstrual period: _____

(Signature)

(date)

FAMILY CHIROPRACTIC

Acceptance of Responsibility

I, the undersigned, accept responsibility for any bills that I incur. If for any reason my insurance does not cover these expenses, I understand that I will be solely responsible. If my Insurance coverage includes a co-payment, I will also be responsible for the amount of each co-payment.

Signature

Date