Cherry Street Chiropractic and Wellness Center

Vehicle Accident Report

Patient Name: _____Date:_____

1) Date of Accident ____/____/____ Time of Accident _____: _____ (AM/PM)
2) Were you: A) Driver B) Passenger (Front) C) Passenger (Rear) D) Pedestrian
3) Were you wearing your seatbelts? (Y/N)
4) Type of Vehicle: A) Auto B) Truck C) Van D) Motorcycle E) Motor Home F) Bicycle
5) How accident occurred: A) Struck by another vehicle B) Struck another vehicle
   C) Struck a stationary object D) Other_____
6) Where was your vehicle hit? A) Front B) Rear C) Right Side D) Left.Side E) Right Front F) Left Front
   G) Right Rear H) Left Rear
7) Where was the other vehicle hit? A) Front B) Rear C) Right Side D) Left Side E) Right Front F) Left Front
   G) Right Rear H) Left Rear
8) Your approximate speed _____ MPH Other vehicle approximate speed _____ MPH
9) What occurred at the moment of impact? (Circle as many as apply)

a) Tensed body from impact	c) Spine torqued and twisted	f) Pinned in vehicle
b) Neck whipped forward & back	d) Thrown over seat	g) Thrown from side to side
	e) Thrown from vehicle	h) Cut and bruised

10) Did you strike your: (Circle as many as apply)

a) Head	Against the: 1) Dashboard 2) Windshield 3) Steering Wheel 4) Rt. Door 5) Left Door 6) Seat Frame 7) Unknown Object
b) Shoulder (Left/Rt)	Against the: 1) Dashboard 2) Windshield 3) Steering Wheel 4) Rt. Door 5) Left Door 6) Seat Frame 7) Unknown Object
c) Arm (Left/Rt)	Against the: 1) Dashboard 2) Windshield 3) Steering Wheel 4) Rt. Door 5) Left Door 6) Seat Frame 7) Unknown Object
d) Elbow (Left/Rt)	Against the: 1) Dashboard 2) Windshield 3) Steering Wheel 4) Rt. Door 5) Left Door 6) Seat Frame 7) Unknown Object
e) Wrist (Left/Rt)	Against the: 1) Dashboard 2) Windshield 3) Steering Wheel 4) Rt. Door 5) Left Door 6) Seat Frame 7) Unknown Object
f) Hip (Left/Rt)	Against the: 1) Dashboard 2) Windshield 3) Steering Wheel 4) Rt. Door 5) Left Door 6) Seat Frame 7) Unknown Object
g) Knee (Left/Rt)	Against the: 1) Dashboard 2) Windshield 3) Steering Wheel 4) Rt. Door 5) Left Door 6) Seat Frame 7) Unknown Object
h) Ankle (Left/Rt)	Against the: 1) Dashboard 2) Windshield 3) Steering Wheel 4) Rt. Door 5) Left Door 6) Seat Frame 7) Unknown Object

11) Were you rendered unconscious? (Y/N)
    Did you receive medical attention at the scene of the accident? (Y/N)
12) Where did you go immediately following the accident?
    A) Hospital B) Home C) Personal Doctor D) To this office E) Resumed activities
13) Were you (Circle as many as apply) A) Shaken B) Disoriented

Did you have any physical complaints before accident? (Y/N) If "YES" please describe:
_____
_____
In your own words, please describe the accident: _____
_____
_____
How did you feel immediately after the accident? _____
_____
_____

Important: This form may be used in the determination of insurance benefits and/or litigation for compensation. It is imperative that this form be filled out completely to protect your rights to compensation.

Cherry Street Chiropractic and Wellness Center
Your Family Chiropractor
1825 East 15th Street Tulsa, Oklahoma 74104 (918) 712-2220

Auto Claim Information

Dear Patient,

In order for us to fill out the proper lien forms for your accident case, we will need your assistance. Please answer the following questions to the best of your knowledge. These questions pertain to the person who was at fault.

Date of Accident: _____

Name of Policy Holder: _____
Address: _____

Insurance Company Information:
Name: _____
Address: _____
Phone Number: _____
Policy Number: _____

Case Adjuster: _____
Address: _____

Claim Number: _____

Type of Vehicle: _____
Insured Party: _____
****Please provide this office with a copy of the accident report.**

Please answer the following questions pertaining to your personal car insurance:

Insurance Company: _____
Agent: _____
Address: _____
Policy Number: _____
Case Adjuster: _____
Address: _____
Claim Number: _____

****Do you have Med Pay Coverage on your Auto Insurance?** _____

Thank you for your assistance.

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Assignment, Lien, and Authorization
Insurance Benefits and Attorney

Patient Name _____ Chart # _____

To Whom It May Concern:

I herby authorize and direct you, my insurance company, and/or my attorney, to pay directly to _____ such sums as may be due and owing this Office for services rendered me, both by reason of accident of illness, and by reason of any other bills that are due this office and to withhold such sums from any disability benefits, medical payments benefits, No-Fault benefits, health and accident benefits, workmen's compensation benefits, or any other insurance benefits obligated to reimburse me or from any settlement, judgment, or verdict on my behalf as may be necessary to adequately protect said Office. I hereby further give a lien to said Office against any and all insurance benefits named herein, and any and all proceeds of any settlement, judgment, or verdict which may be paid to me as a result of the injuries or illness for which I have been treated by said Office. This is to act as an assignment of my rights and benefits to the extent of the Office's services provided.

In the event my insurance company obligated to make payments to me upon the charges made by this Office for their services refuses to make such payments, upon demand by me or this Office, I hereby assign and transfer to this Office any and all causes of action that I might have or that might exist in my favor against such company and authorize this Office to prosecute said cause of action either in my name or in the Office's name and further I authorize this Office to compromise, settle or otherwise resolve said claim or cause of action as they see fit.

I understand that I remain personally responsible for the total amounts due the Office for their services. I further understand and agree that this Assignment, Lien and Authorization does not constitute any consideration for the Office to await payments and they may demand payments from me immediately upon rendering services at their option.

I authorize the Office to release any information pertinent to my case to any insurance company, adjuster or attorney to facilitate collection under this Assignment, Lien and Authorization. I agree that the above mentioned Office be given power of Attorney to endorse/sign my name on any and all checks for payment of my doctor bill.

Date: _____ **Signed: _____**
Printed: _____