# Automobile Accident Questionnaire

## Accident Information

Name:_____ Date:_____

1. Date of Accident: _____ Time:_____ a.m./p.m.

2. Driver of car: _____ Where you were seated:_____

3. Owner of car: _____ Year and Model of car:_____

4. Visibility at time of accident: poor/fair/good/other: _____

5. Road conditions at time of accident: icy/rainy/wet/clear/dark/other: _____

6. Where was your car struck? right/left/rear/front/side/other: _____

7. Type of accident: ❑ head-on collision ❑ broad-side collision ❑ rear-end collision

❑ front impact, rear-ended car in front ❑ non-collision: _____

8. What part of the car was damaged? _____

9. Describe what happened to you upon impact? _____

10. Did you see the accident was about to happen? ❑ Yes ❑ No

11. Did you brace for impact? ❑ Yes ❑ No

12. Were you wearing a seatbelt? ❑ Yes ❑ No

13. Were you wearing a shoulder harness? ❑ Yes ❑ No

14. Does the car have headrests? ❑ Yes ❑ No

15. If yes, what was the position of your headrest? ❑ top of headrest even with bottom of head

❑ top of headrest even with top of head ❑ top of headrest even with middle of head

16. Was your car braking? ❑ Yes ❑ No Was the other car braking? ❑ Yes ❑ No

17. Was your car moving at the time of the accident? ❑ Yes ❑ No

If yes, how fast would you estimate you were going? _____

18. How fast would you estimate the other car was traveling? _____

19. What was the position of your head and body at the time of impact?

❑ head turned left/right ❑ body straight in sitting position ❑ head looking back

❑ body rotated left/right ❑ head straight forward ❑ other:_____

20. At the time of the accident, recall what parts of your head or body hit what parts of the vehicle:

_____

_____

21. As a result of the accident were you: ❑ rendered unconscious ❑ dazed ❑ other: _____

22. Could you move all parts of your body? ❑ yes ❑ no

If no, why not? _____

23. Were you able to get out of the car and walk unaided? ❑ yes ❑ no

If no, why not? _____

24. Did you have any cuts or bruises from this accident? ❑ yes ❑ no

If so, where? _____

25. Describe how you felt immediately after the accident? _____

_____

How did you feel later that ❑ day ❑ night? _____

How did you feel the next day(s)? _____

26. Check symptoms apparent <u>since</u> the accident:

| | | | |
|---|---|---|---|
| ❑ headache | ❑ loss of smell | ❑ numbness in fingers | ❑ neck pain/stiffness |
| ❑ loss of taste | ❑ cold hands | ❑ mid-back pain | ❑ loss of memory |
| ❑ cold feet | ❑ low-back pain | ❑ fatigue | ❑ diarrhea |
| ❑ tension | ❑ constipation | ❑ pain behind eyes | ❑ shortness of breath |
| ❑ chest pain | ❑ dizziness | ❑ irritability | ❑ nervousness |
| ❑ fainting | ❑ depression | ❑ cold sweats | ❑ anxious |
| ❑ sleeping problems | ❑ loss of balance | ❑ numbness in toes | |
| ❑ ringing/buzzing in ears | | ❑ eyes sensitive to light | ❑ other:_____ |

27. Have you missed time from work? ❑ yes ❑ no Work hours are: ❑ full-time ❑ part-time

If you have missed time from work, how much time have you missed? _____

28. Did the accident occur during your work hours? ❑ yes ❑ no

29. Did you seek medical help immediately/soon after the accident? ❑ yes ❑ no

If yes, how did you get there? _____

30. Doctor/hospital/clinic seen: _____ Date: _____

31. What was done? _____

Were x-rays taken? ❑ yes ❑ no If yes, of what body part? _____

32. What treatments/prescriptions were given? ❑ bed rest ❑ brace ❑ adjustments ❑ medications

33. What benefit(s) did you receive from treatment(s)? _____

_____

34. Date of last treatment: _____

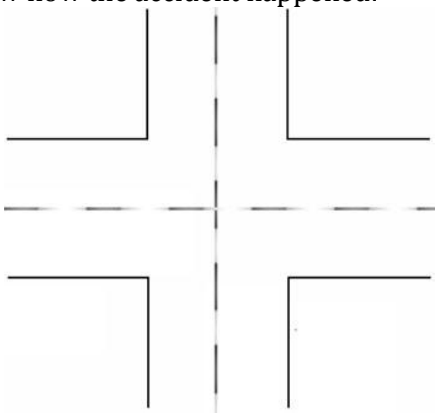
35. Are any of your activities of daily living any different now compared to before the accident?
❑ yes ❑ no

List anything you are unable to do: _____

List anything that is painful to do: _____

List anything that is difficult to do: _____

36. Indicate on the diagram below how the accident happened:



Comments: _____

_____

37. Do you have an attorney handling this case? ☐ yes ☐ no

If yes, who? (name/address)

***Insurance Information***

Patient's personal insurance:

Insured's name (if other than patient)

Policy #:

Insurance Company Name:

Phone#:

Address: City: State/Zip:

Claim #: Adjuster's name/phone:

Other party's insurance:

Insured's name (if other than patient) Policy #:

Insurance Company Name: Phone#:

Address: City: State/Zip:

Claim #: Adjuster's name/phone:

Other insurance:

Insured's name (if other than patient) Policy #:

Insurance Company Name:

Phone#:

Address: City: State/Zip:

# Assignment of Benefits Form

**Kerner Chiropractic**
Brian M. Kerner, DC
3106 Fillmore Street
San Francisco, CA 94123

Date: _____

Patient: _____

Insurance: _____

Claim Number: _____

I hereby instruct and direct _____ Insurance Company to pay by check made out and mailed to the above address for my doctor, **OR,** if my current policy prohibits direct payment to doctor, I hereby also instruct and direct you to make out the check to me and mail it to the above address for my doctor as following:

*for the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered.* ***THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.*** *This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.*

A photocopy of this Assignment shall be considered as effective and valid as the original. I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

I authorize doctor to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

Dated this _____ day of _____, 20_____

Signature of Policyholder: _____

Signature of Claimant, if other than Policyholder _____

Kerner Chiropractic

Brian M. Kerner, DC, QME

3106 Fillmore Street
San Francisco, CA 94123
Phone: (415) 563-2452
Fax: (415) 563-2517

www.kernerchiropractic.com

# PERSONAL INJURY FINANCIAL AGREEMENT

We would like to take a moment to welcome you to our office and to assure you that you will receive the very best care available for your injury. In order to familiarize you with the financial policy of our office, I would like to explain how your medical bills will be handled.

***PARTY RESPONSIBLE:***

If you were involved in an auto accident in your own vehicle, we will bill the medical payments portion or Personal Injury Protection portion of your insurance policy to cover the treatment charges incurred in our office.

*MEDPAY:* If you were a passenger in another vehicle, the insurance company which insures the automobile may be billed for your medical services incurred.

*PIP (Personal Injury Protection):* If you were a passenger in another vehicle, and you own a car which has PIP coverage, the insurance company which carries your policy will be responsible to pay your medical bills.

*3rd PARTY:* If another vehicle has caused the accident, we will first bill your automobile MedPay or PIP.

It is also to your advantage for our office to bill your own health insurance policy for your medical services, providing your policy does not state otherwise. Any amount received above and beyond your total bill in this office will be refunded to you.

***ATTORNEY LIENS:***

If you hire an attorney to represent you in a law suit, it is our policy to have your attorney sign a Doctor's Lien. This will guarantee direct payment to our office for any undid balance upon the settlement of your law suit. We retain the right to first submit all charges to your private and/or auto insurance policy for payment. Further, this office does not discount or reduce the amount of your balance based upon the outcome of your settlement.

***RESPONSIBILITY FOR PAYMENT:***

As a courtesy to you, we will gladly submit your charges to your insurance company(ies) and/or your attorney; however, all services rendered by this office are charged directly to you, and ultimately, you are personally responsible for payment of these charges, regardless of any insurance reimbursement or settlement you may or may not receive.

Once again, we welcome you to our office. We hope that this has answered any questions that you might have about our financial arrangements. If, at any time, you have further questions about your care, please do not hesitate to ask.

***I have read and agree to the above.***

Patient's Signature

Date