

AUTOMOBILE ACCIDENT HISTORY FORM

Your Name _____ Today's Date _____

Date of Accident _____ Time of Accident _____ am/pm

City of Accident _____ Street of Accident _____

Road conditions at the time of the accident: WET DRY ICY
OTHER _____

Did the police come to the accident scene? YES NO Is there a report? YES NO

Did you go to a hospital? YES NO

If yes, what is the name and city of the hospital? _____

How did you get to the hospital? _____

What parts of your body were x-rayed at the hospital? _____

What did the hospital do for your injuries? _____

How long did you stay at the hospital? _____

What bleeding cuts did you sustain during this accident? _____

What bruises did you sustain during this accident? _____

Where were you seated in the vehicle? _____

Were you aware of the approaching collision prior to impact, or did impact catch you by

Surprise? AWARE SURPRISE

Did you lose consciousness (black out) upon impact? YES NO How long _____

Did you experience a flash of light or explosion in your head? YES NO

Did you become CONFUSED DISORIENTED LIGHT HEADED DIZZY NAUSEATED

BLURRED VISION RING/BUZZ IN EARS from the accident? (Please circle all that apply).

Do you still have any of those symptoms? Which ones? _____

Are you currently suffering from any of the following? (Please circle all that apply).

RESTLESSNESS
DIFFICULT CONCENTRATING
SLEEPLESSNESS
REDUCED TOLERANCE TO HEAT

IRRITABLE
DIFFICULT WITH MEMORY
FORGETFULNESS
REDUCED TOLERANCE TO ALCOHOL

How far is the top of the headrest or seatback from the top of your head (approximately)?
_____ inches Above or Below

Were you wearing a seatbelt? YES NO

If yes, was it a lap seatbelt _____ shoulder-lap seatbelt _____

List the year, make and model of the vehicle you were in:

Year _____ Make _____ Model _____

Was your car stopped at the time of impact? YES NO

If yes, was the driver's foot also on the brake? YES NO

If no, then estimate the speed of the vehicle you were in: _____ MPH

If your vehicle was moving at the time of impact, was it:

Slowing down? YES NO

Gaining Speed? YES NO

Traveling at a steady rate of speed? YES NO

On what part of the automobile did your following body parts hit?

Head hit _____ Chest hit _____

Right/Left shoulder hit _____ Right/Left arm hit _____

Right/Left hip hit _____ Right/Left leg hit _____

Right/Left knee hit _____ Other _____

Did you receive any injury or bruise from the seat belt? YES NO

If YES, then describe: _____

What is the estimated cost damage to the vehicle you were in? _____

Which of the following car parts broke during the accident? (Please circle)

Windshield _____ Front seat back _____

Right/Left side window _____ Other _____

Steering wheel

Other _____

Was the trunk of your body pointed straight forward at the time of the collision?

YES NO: If NO, how was it turned? _____

Was your head pointed straight forward? YES NO: If NO, what direction was it turned and by how much? _____

What is the Year, Make and Model of the **(Other)** Vehicle?

Year _____ Make _____ Model _____

Was the other vehicle moving at the time of the collision? YES NO

If YES, what was its approximate speed? _____ MPH

If the other vehicle was moving at the time of the collision, was it (Please Circle):

Slowing Down Gaining Speed Traveling at a Steady Speed

Please describe, to the best of your knowledge, what happened during this accident:

**IRREVOCABLE ASSIGNMENT, LIEN and AUTHORIZATION
INSURANCE BENEFITS and ATTORNEY**

Claim or File # _____ Insured's Name _____

Date of Loss: _____ Address: _____

Patient: _____

Policy # _____

To whom it may concern:

I hereby authorize and direct you my insurance company, liability insurance adjustor, and/or my attorney, to pay directly to:

Bowman Chiropractic & Rehabilitation **(OR)**
107 Shiloh Dr. Suite B
Mt. Vernon, IL 62864

Bowman Chiropractic
202 South Broadway
Salem, IL 62881

Such as may be due and owing these offices for services rendered me, both by reason of accident or illness, and by reason of any other bills that are due these offices, and to withhold such sums from any disability benefits, medical payment 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 which may be paid to me as a result of the injuries or illness for which I have been treated by said offices. This is to act as an assignment of my rights and benefits to the extent of the office's 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 these office's. I hereby assign and transfer to these office's any and all causes of action that I might have or that might exist in my favor against such company and authorize these office's to prosecute said cause of action either in my name or in the office's name and further I authorize these office's 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 offices for their services. I further understand and agree that this Assignment, Lien and Authorization do not constitute any consideration for the office's to await payments and they may demand payments from me immediately upon rendering services at their option. And I further understand that such payment is not contingent on any settlement, judgment or verdict by

which I may eventually recover said fee. I agree to pay all costs of collection of any balance due these offices, including reasonable attorney's fees.

I authorize the offices to release any information pertinent to my case to any insurance company, adjustor or attorney to facilitate collection under this Assignment, Lien and Authorization. I agree that the above mentioned offices be given Power of Attorney to endorse/sign my name on any and all checks for payment of my doctor bill. I hereby instruct that in the event another attorney is substituted in this matter, the new attorney honor this lien as inherent to the settlement and enforceable upon the case as if it were executed by him. A photocopy of this agreement shall be considered as effective and valid as the original.

Date _____ Signed _____

Witness _____

The undersigned being attorney of record for the above patient does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgment, or verdict, as may be necessary to adequately protect said doctor above named.

Date _____ Signed _____

Note to attorney: If you refer please send your acknowledgement of this lien on your letterhead.