SPINE CENTER
MYRTLE BEACH

VEHICLE ACCIDENT INFORMATION

PATIENT INFORMATION

Date:_____

Patient Name: _____

Date of Accident_____Time of Accident : _____ ☐ AM ☐ PM

Please describe the accident in your own words:

_____

_____

_____

Were you the: ☐ Driver ☐ Rear Passenger ☐ Front Passenger ☐ Pedestrian

How many people in the accident vehicle? _____

ACCIDENT SITE

Read/Street Name:_____

City/State:_____

Nearest Intersection with Road / Street:_____

Driving conditions: ☐ Dry ☐ Wet ☐ Icy ☐ Other

Which direction were you headed?_____

Speed you were traveling?_____

VEHICLE

Make and model of vehicle you were in:_____

Were you wearing a seatbelt? ☐ Yes ☐ No

If yes, what type? ☐ Lap ☐ Shoulder

Was vehicle equipped with airbags? ☐ Yes ☐ No

If yes, did it/they inflate properly? ☐ Yes ☐ No

Did your seat have a headrest? ☐ Yes ☐ No

If yes, what was the position of the headrest?

☐ Low ☐ Mid position ☐ High

OTHER VEHICLE (if applicable)

Make and model of other vehicle?_____

Which direction was the other vehicle headed?

_____

Speed of the other vehicle?_____

IMPACT

Did your car impact another vehicle? ☐ Yes ☐ No

Did your car impact a structure? ☐ Yes ☐ No

If yes, explain_____

Did any part of your body strike anything in the vehicle?

☐ Yes ☐ No If yes, explain _____

Was impact from:

☐ Front ☐ Rear ☐ Left ☐ Right ☐ Other

At the time of impact were you:

☐ Looking straight ahead ☐ Looking to the right

☐ Looking to the left ☐ Looking down

☐ Looking Up

Were both hands on the steering wheel? ☐ Yes ☐ No

If no, which hand was on the wheel? ☐ Right ☐ Left

Was your foot on the brake? ☐ Yes ☐ No

If yes, which foot was on the brake? ☐ Right ☐ Left

Were you: ☐ Surprised by impact ☐ Braced for impact

POLICE

Did the police come to the accident site? ☐ Yes ☐ No

Were there any witnesses? ☐ Yes ☐ No

Was a police report filed? ☐ Yes ☐ No

Was a traffic violation issued? ☐ Yes ☐ No

If yes, to whom? _____

PATIENT CONDITION

Were you unconscious immediately after the accident? ☐ Yes ☐ No If yes, for how long? _____

Please describe how you felt immediately after the accident:

_____

_____

TREATMENT

Did you go to the hospital? ☐ Yes ☐ No

When did you go? ☐ Immediately after accident ☐ Next Day ☐ 2 days or more after the accident

How did you get to the hospital? ☐ Ambulance ☐ Private transportation

Name of hospital _____ Name of doctor _____

Diagnosis _____

_____

Treatment received _____

X-rays taken _____

SYMPTOMS/INJURIES

Have you been able to work since this injury? ☐ Yes ☐ No How many work days have you missed?_____

Prior to the injury were you able to work on an equal basis with others your age? ☐ Yes ☐ No

If you have had any of the following symptoms since your injury, Please Select:

☐ Arm/shoulder pain	☐ Back pain	☐ Back stiffness	☐ Chest pain
☐ Dizziness	☐ Ear buzzing	☐ Ear ringing	☐ Fatigue
☐ Feet/toe numbness	☐ Hand/finger numbness	☐ Headaches	☐ Irritability
☐ Jaw problems	☐ Leg pain	☐ Memory loss	☐ Nausea
☐ Neck pain Neck stiff	☐ Shortness of breath	☐ Sleep difficulty	
☐ Stomach upset	☐ Tension	☐ Vision blurred	

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.

Rate the severity of your pain on a scale from 1 (least pain) to 10 (sever pain) _____

Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting
☐ Burning ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Tingling ☐ Other

How often do you have this pain? _____

Is it constant or does it come and go? _____

Does it interfere with your: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Movements that are painful to perform: ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Laying Down

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my child, ever have a change in health.

Signature of Patient, Parent, Guardian or Personal Representative _____ Date_____

Print name of Patient, Parent, Guardian or Personal Representative _____

_____

Relationship to Patient _____

OFFICE POLICIES FOR PERSONAL INJURY PATIENTS

This office will accept you as a new patient based on our clinical examination and belief that chiropractic care will be effective for the treatment of your injuries. Your responsibility to this office will be to follow the doctor's recommendations and to provide the appropriate financial information so that payment for services can be received.

Patients need to bring the following:

- Copy of the police report and/or a copy of the exchange slip.
- Copy of personal automobile policy This is to verify medical payments covered by your automobile insurance.
- Name of individual and insurance company of party that's liable. Please include the policy number.
- Name and telephone number of attorney if an attorney has been retained.

You are asked to give 24 hour notice if you need to reschedule an appointment. All appointments that have been missed without notice may be billed to your account.

Signature : _____ Date: _____

LIEN

Myrtle Beach Spine Center,
PA 100 Legends Drive,
Suite A, Myrtle Beach, SC 29579

TO: Attorney / Insurance carrier
_____
_____
_____

RE: Patient Records and Doctor's Lien.

I do hereby authorize the above doctor to furnish you, my attorney/insurance carrier, with a full report concerning all examination, diagnosis, and treatment of myself in regard to my accident/illness that occurred/began in _____.

I hereby give a lien to said doctor on any settlement, claim, judgement, or verdict as a result of said accident/illness and authorize and direct you, my attorney/insurance carrier, to pay directly to said doctor out of first proceeds such sums from settlement, claim, judgement, or verdict as may be necessary to protect the doctor adequately. First proceeds are inclusive of any and all insurance benefits that might be in force, PIP, Med Pay, and Group Health. I have further given the attending physician permission to endorse my name on all checks received on my behalf. I therefore request that all checks or drafts be sent directly to and made payable to the attending physician.

I fully understand that I am directly and fully responsible to said doctor for all medical bills submitted by him for services rendered to me and that this agreement is made solely for the said doctor's additional protection and in consideration of awaiting his payment. It is for this reason that I have given him all rights to the first proceeds in this case necessary to protect the charges that I have incurred. I fully understand that such payment is not contingent on any settlement, claim, judgment, or verdict by which I may eventually recover said fee.

I have voluntarily entered into the above contract and lien with the attending physician, and it has been fully explained to me. By this lien and contract, I am putting all parties on notice of my obligations as well as the way I wish my business to be transacted in this matter.

I am requesting my attorney and/or any other interested parties to make signatures on this form acknowledging its receipt. However, in the event that they do not choose to sign the form, for whatever reason, I wish to point out that they have been priced on to notice that a contract exists between myself and the attending physician; I order that they have honor this contract in full. I hereby state and agree that the lien may not be withdrawn unilaterally. It is further agreed that a copy of this agreement will be considered the same as the original.
Should I dismiss any attorney of record, I authorize that attorney to provide you with all information regarding this claim that he has in his possession. This includes, but is not limited to, the names of all insurance companies, adjusters, and claim numbers.

Dated:_____ Patient's Signature: _____

The undersigned, being attorney of record or authorized representative of the insurance carrier for the above patient, does herby acknowledge receipt of the above lien and does agree to honor the same to adequately protect the above-named doctor.

Dated: _____ Authorized Signature:_____

NOTICE: Please date, sign, and return one copy to the doctor's office at once. Keep one copy for your records.

AUTHORIZATION AND ASSIGNMENT

TO : Myrtle Beach Spine Center, PA

In consideration of your undertaking to treat me, I agree to the following:

- You are authorized to release any information concerning my physical condition to any insurance company, attorney, or adjuster in order to process my claim for reimbursement of charges incurred for services rendered to me by you or any member of your staff acting on your behalf. It is further agreed, however, that until my account is paid in full or that there is adequate promise of payment that is approved by you, medical records do not have to be sent.

- I request, authorize, and further direct that any insurance company which is obligated to reimburse for services rendered or pay for damages make such payments directly to you. I further direct that checks should be made payable to you or the clinic, specifically, so that you may obtain immediate payment. Insofar as any payment is concerned, I allow you to stand in my place and receive all payments as they would have been made to me. I further authorize and give my permission to you to endorse any and all checks, drafts, or payments received on my behalf. Thus, authorization is to endorse checks, whether they be received for settlement purposes or services rendered. It is further understood that if at any point the monies received exceed my indebtedness, those funds will be returned to me from your office.

- I hereby assign and transfer to you any cause of action (tort liability) that exists in my favor against such company, individual, or insurance company, which are liable to provide, defend, and pay damages (the names which are believed to be correctly set forth under permanent data below) and authorize you to prosecute said action, either in my name or in your name, as you see fit. It is agreed, however, that in transferring this cause of action, it is agreed between all parties that your interest in this cause shall be limited to the amount of the medical bills rendered to me by you or your appointee at any of your clinic facilities. It is further understood and agreed by all parties that the transfer of this cause of action shall not exceed those medical bills that are rendered for my benefit and that are related to the case in question. For the above-named purpose, I further authorize and transfer to you my limited power of attorney so that you may act on my behalf in this regard, and in this regard only. It is further understood that until all reasonable efforts have been made to collect sums due from the insurance carriers obligated, you will refrain from attempts to collect amounts from me. I understand whatever amount you do not collect from insurance proceeds, whether it be all or part of what is due, I personally owe you.

DATE: _____ SIGNED:_____

WITNESSED: _____ DATE OF INJURY:_____

PERTINENT DATA

Names of insurance companies to be involved:

My companies:	Companies of person responsible for accident:
_____	_____
_____	_____

I hereby state and agree that a photocopy of this document will be deemed as valid and binding on all parties involved.

CHIROPRACTIC AUTHORIZATION, RELEASE, AND EXPLANATION

Medical Notes and X-Ray Release

I hereby acknowledge the release of medical information, S.O.A.P. notes, and x-ray reports to Myrtle Beach Spine Center PA.

_____ _____

(Patient Signature) (Date)

_____ _____

(Witness Signature) (Date)