

## ACCIDENT HISTORY

If a particular question does not apply, please write N/A in the available space.

1. Date of accident \_\_\_\_\_ Time \_\_\_\_\_
2. Full Name \_\_\_\_\_ Birth date \_\_\_\_\_
3. Home Address \_\_\_\_\_
4. City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_
5. Home Phone \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_
6. Marital Status:     M     S     W     D
7. Social Security# \_\_\_\_\_
8. Occupation \_\_\_\_\_ Employer \_\_\_\_\_  
Employer's Address \_\_\_\_\_
9. Spouse's name \_\_\_\_\_ Birth date \_\_\_\_\_  
Social Security # \_\_\_\_\_ Work # \_\_\_\_\_ Cell # \_\_\_\_\_
10. Spouse's Occupation \_\_\_\_\_ Employer \_\_\_\_\_  
Employer's Address \_\_\_\_\_
11. Nearest relative not living with you \_\_\_\_\_  
Phone# \_\_\_\_\_ Relationship \_\_\_\_\_  
City/State \_\_\_\_\_
12. Was this a car accident? \_\_\_\_\_ If other, please explain \_\_\_\_\_  
\_\_\_\_\_
13. Were you aware that the accident was going to happen? Yes \_\_\_\_\_ No \_\_\_\_\_
14. Please check one: \_\_\_\_\_ Driver \_\_\_\_\_ Passenger \_\_\_\_\_
15. Location of accident \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_
16. Please check one: \_\_\_ Traveling \_\_\_ Stopped
17. Facing which direction? \_\_\_ North \_\_\_ South \_\_\_ East \_\_\_ West
18. Other vehicle facing which direction? \_\_\_ North \_\_\_ South \_\_\_ East \_\_\_ West
19. Number of people in YOUR vehicle \_\_\_\_\_ Number of people in OTHER \_\_\_\_\_
20. Which of the following occurred:\_  
\_\_\_ Stopped at red light and car rear-ended  
\_\_\_ Vehicles collided head on \_\_\_\_\_  
\_\_\_ Other vehicle ran stop sign or red light  
\_\_\_ Lost control of car  
Other \_\_\_\_\_  
\_\_\_\_\_
21. Did your airbag go off? \_\_\_ Yes \_\_\_ No
22. Did you strike any objects inside of car? \_\_\_ Yes \_\_\_ No  
\_\_\_\_\_ Dashboard \_\_\_\_\_ Steering Column \_\_\_\_\_ Windshield  
\_\_\_\_\_ Headrest \_\_\_\_\_ Rearview Mirror \_\_\_\_\_ Seat Broke  
\_\_\_\_\_ Can not remember details Other \_\_\_\_\_

- Name \_\_\_\_\_
23. What part of your body did you strike?  
 \_\_\_\_\_ Head \_\_\_\_\_ Chest \_\_\_\_\_ Face  
 \_\_\_\_\_ Knees \_\_\_\_\_ Arms \_\_\_\_\_ Other
24. Were you rendered unconscious: \_\_\_\_ Yes \_\_\_\_ No
25. Were you cut or bleeding? \_\_\_\_ Yes \_\_\_\_ No If cut, please explain where:  
 \_\_\_\_\_
26. Were you wearing a seatbelt? \_\_\_\_ Yes \_\_\_\_ No  
 \_\_\_\_\_ Lap \_\_\_\_\_ Shoulder \_\_\_\_\_ Both
27. Did you feel any pain following the accident? \_\_\_\_ Yes \_\_\_\_ No  
 When? \_\_\_\_\_ During the accident \_\_\_\_\_ Immediately after \_\_\_\_\_  
 \_\_\_\_\_ Later that day \_\_\_\_\_ Next day \_\_\_\_\_ Several days later  
 If yes, please explain: RIGHT SIDE LEFT SIDE  
 \_\_\_\_\_ Headaches \_\_\_\_\_  
 \_\_\_\_\_ Neck pain \_\_\_\_\_  
 \_\_\_\_\_ Mid back pain \_\_\_\_\_  
 \_\_\_\_\_ Low back pain \_\_\_\_\_  
 \_\_\_\_\_ Other \_\_\_\_\_
28. After the accident, did you:  
 \_\_\_\_\_ Go home \_\_\_\_\_ Go about your business \_\_\_\_\_ Go to the hospital
29. If taken to the hospital, how?  
 \_\_\_\_\_ Ambulance \_\_\_\_\_ Driven by someone  
 \_\_\_\_\_ Drove yourself \_\_\_\_\_ Went to the hospital at later date
30. Name of hospital \_\_\_\_\_
31. Were you seen in the emergency room? \_\_\_\_ Yes \_\_\_\_ No
32. Were you admitted to the hospital? \_\_\_\_ Yes \_\_\_\_ No
33. If admitted, how long did you stay? \_\_\_\_\_
34. Name of admitting or hospital physician \_\_\_\_\_
35. In the emergency room or hospital, which of the following were performed?  
 \_\_\_\_\_ Examination \_\_\_\_\_ Stitches  
 \_\_\_\_\_ Xrays \_\_\_\_\_ Prescription \_\_\_\_\_  
 \_\_\_\_\_ Physiotherapy \_\_\_\_\_ Cervical collar  
 \_\_\_\_\_ Complete bed rest \_\_\_\_\_ Other \_\_\_\_\_
36. Following the accident or after your hospital release, where did you go?  
 \_\_\_Returned home to bed \_\_\_Returned to work  
 Other \_\_\_\_\_
37. When did you first consult a physician following this accident (other than this clinic)?  
 \_\_\_\_\_ Same day \_\_\_\_\_ Within a few days  
 \_\_\_\_\_ Following day \_\_\_\_\_ No visits with other physicians
38. Who did you consult following the accident? Doctor \_\_\_\_\_  
 Doctor's specialty: \_\_\_\_\_ Family physician \_\_\_\_\_ Chiropractor  
 \_\_\_\_\_ Orthopedic \_\_\_\_\_ Osteopath  
 \_\_\_\_\_ Neurologist \_\_\_\_\_ Other \_\_\_\_\_
39. What did the doctor do? \_\_\_\_\_ Examination \_\_\_\_\_ Injections \_\_\_\_\_ X-rays  
 \_\_\_\_\_ Physiotherapy \_\_\_\_\_ Traction \_\_\_\_\_ Other  
 Prescriptions: \_\_\_\_\_
40. How long were you under the care of a physician? \_\_\_\_\_
41. Did the doctor refer you to any other physicians? \_\_\_\_ Yes \_\_\_\_ No

Name \_\_\_\_\_

42. Currently, I have pain in my \_\_\_Neck \_\_\_Mid back \_\_\_Low back

Neck/Mid back pain:

I have pain: \_\_\_\_\_ Sometimes \_\_\_\_\_ All of the time

My pain goes into my: \_\_\_\_\_ Right arm \_\_\_\_\_ Left arm \_\_\_\_\_ Both arms

I have tingling/numbness in: \_\_\_\_\_ Right arm \_\_\_\_\_ Left arm \_\_\_\_\_ Both arms

Pain is worse when I:

\_\_\_\_\_ Sneeze \_\_\_\_\_ Cough \_\_\_\_\_ Bend \_\_\_\_\_ Take a deep breath

\_\_\_\_\_ Lift \_\_\_\_\_ Push \_\_\_\_\_ Pull \_\_\_\_\_ Turn my head

\_\_\_\_\_ My pain wakes me up at night

If I do get headaches, they occur: \_\_\_\_\_ Sometimes \_\_\_\_\_ All of the time

I have headaches \_\_\_\_\_ times a week

Low Back Pain:

I have pain: \_\_\_\_\_ Sometimes \_\_\_\_\_ All of the time

Pain goes into my: \_\_\_\_\_ Right leg \_\_\_\_\_ Left leg \_\_\_\_\_ Both legs

I have tingling/numbness in: \_\_\_\_\_ Right leg \_\_\_\_\_ Left leg \_\_\_\_\_ Both legs

My pain is worse when I:

\_\_\_\_\_ Cough \_\_\_\_\_ Sit \_\_\_\_\_ Bend \_\_\_\_\_ Take a deep breath

\_\_\_\_\_ Lift \_\_\_\_\_ Walk \_\_\_\_\_ Pull \_\_\_\_\_ Push

\_\_\_\_\_ My pain wakes me up at night

43. Other current symptoms? \_\_\_\_\_  
\_\_\_\_\_

44. Have you ever been treated for neck or back problems by any other physicians prior to this accident? \_\_\_\_\_ Yes \_\_\_\_\_ No If yes, please explain why:  
\_\_\_\_\_  
\_\_\_\_\_

45. Have you had previous surgeries or conditions that I should be aware of?  
\_\_\_\_\_

46. Have you lost time from work due to the accident? \_\_\_\_\_ Yes \_\_\_\_\_ No

Type of work performed: \_\_\_\_\_

47. Date returned to work: \_\_\_\_\_

48. Do you notice any activity restrictions as a result of this injury? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, describe in detail:  
\_\_\_\_\_  
\_\_\_\_\_

49. Name of attorney handling the case: \_\_\_\_\_ Claim # \_\_\_\_\_

Attorney Phone # \_\_\_\_\_

Other pertinent information: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Patient Name – PRINTED

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient – SIGNATURE

## PATIENT REQUEST FOR RECORDS

**DATE:** \_\_\_\_\_

**TO:** \_\_\_\_\_

**ADDRESS:** \_\_\_\_\_

**CITY:** \_\_\_\_\_ **STATE:** \_\_\_\_\_ **ZIP:** \_\_\_\_\_

I hereby authorize the release of: \_\_\_\_\_ All Medical records  
\_\_\_\_\_ X-rays  
\_\_\_\_\_ Blood work results  
\_\_\_\_\_ MRI results  
\_\_\_\_\_ Other \_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_ Please **MAIL** records to: \_\_\_\_\_ **Dyer Chiropractic Clinic**  
**33 East County Line Rd**  
**Greenwood, IN 46143**

or

\_\_\_\_\_ Please **FAX** records to: \_\_\_\_\_ **FAX: 317-882-4898**

Patient's Printed Name: \_\_\_\_\_

Birthdate: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Patient's Signature: \_\_\_\_\_

**ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO  
DOCTOR PRIVATE AND GROUP ACCIDENT AND HEALTH  
INSURANCE**

I hereby instruct and direct the \_\_\_\_\_ Insurance Company to  
pay by check made out and mailed directly to:

DYER CHIROPRACTIC CLINIC  
33 East County Line Road  
Greenwood, IN 46143

If my current policy prohibits direct payment to doctor, then I hereby also instruct and direct you  
to make out the check to me and mail it as follows:

33 East County Line Road  
Greenwood, IN 46143

**The professional or chiropractic expense benefits allowable and otherwise payable to me under  
my current insurance policy as payment toward the total charges for 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.

Dated this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.

\_\_\_\_\_  
Signature of Policyholder

\_\_\_\_\_  
Signature of Claimant, if other than Policyholder

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Please list any and all doctors seen in the last two years:

**Doctor:** \_\_\_\_\_

Address: \_\_\_\_\_ (if known)

Phone: \_\_\_\_\_

Reason for visit / treatment: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Doctor:** \_\_\_\_\_

Address: \_\_\_\_\_ (if known)

Phone: \_\_\_\_\_

Reason for visit / treatment: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Doctor:** \_\_\_\_\_

Address: \_\_\_\_\_ (if known)

Phone: \_\_\_\_\_

Reason for visit / treatment: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Doctor:** \_\_\_\_\_

Address: \_\_\_\_\_ (if known)

Phone: \_\_\_\_\_

Reason for visit / treatment: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

*(Please print this form again if you need more space)*

**Consent for Use and Disclosure of Health Information**

This notice describes how chiropractic and medical information about you may be used and disclosed, your rights as a patient, and ways for you to get additional information on our policies.

Our clinic has always been very protective and respectful of your personal information. Under new federal regulations (the HIPAA Privacy Act), we have adopted additional guidelines to ensure the proper use, confidentiality and disclosure of your health information.

**We May Release or Disclose Your Health Information:**

- For treatment purposes to another health care provider or clinic if we refer you, or to providers or staff within our clinic that are taking part in your care.
- For billing and collection purposes, we may release records of your health care and information that you have provided to your insurance carrier or other financially responsible parties.
- For operational purposes within our clinic for quality control, office administration, record keeping, staff or provider training.

Specifically, you authorize the release of any information pertinent to your case to any insurance company, adjuster, or attorney involved in this case for the purpose of obtaining payment on your health claims.

We may also use your personal health information to contact you regarding your appointments, to send you information about our clinic or office events, or to share treatment options. We will not disclose information about you to anyone outside our office without your written approval.

You have the right to inspect or obtain a copy of the information we will use for these purposes. You have the right to amend your records at this office. You also have the right to refuse to provide authorization for this office to contact you regarding these matters. If you do not provide us with this authorization it will not affect the care provided to you or the reimbursement avenues associated with your care. Requests to inspect, copy or amend your health related information should be provided to the Front Desk in writing.

We normally provide information about your health to you in person at the time you receive care from us. We may also mail information to you regarding your health care or about the status of your account. If you would like to receive this information at an address other than your home or if you would like the information in a different form, please advise us in writing as to your preferences.

Information that we use or disclose based on this privacy notice may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules.

If you have a complaint regarding our privacy notice, our privacy practices or any aspect of our privacy activities you should direct your complaint in writing to the Clinic Director.

If you would like further information about our privacy policies and practices please see the "Notice of Privacy Practices" binder in reception or ask for a copy at the Front Desk.

\_\_\_\_\_  
Name (print)

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

If you are a minor, or if you are being represented by another party:

\_\_\_\_\_  
Personal Representative Name (Print)

\_\_\_\_\_  
Personal Representative Signature

\_\_\_\_\_  
Date