

## **AUTOMOBILE ACCIDENT OFFICE POLICY**

If you have been injured or suspect you have been injured during an automobile accident **you must tell your insurance company within seven days of the occurrence** of a motor vehicle collision, or as soon as possible. The insurer will promptly provide you with a benefits application package.

Once you have completed your portion of the forms, promptly bring them into our office so that Dr. Mike Mattinen/ or Dr. Lyne Rivet can complete their section with their examination findings.

## **AUTOMOBILE ACCIDENT AUTHORIZATION FOR ACTING UPON**

I hereby authorize Orleans Gardens Chiropractic to act on my behalf to deal with the appropriate claims caused by the automobile accident dated:

\_\_\_\_\_

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

Date of Birth (YY/MM/DD): \_\_\_\_\_

Signature: \_\_\_\_\_

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

\*\*Please note, should your claim be denied by the insurance company **you** will be responsible to pay for any services rendered.

## Motor Vehicle Accident Insurance Information

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

Date of Birth: (YYYY / MM / DD) \_\_\_\_\_

Today's Date: (YYYY / MM / DD) \_\_\_\_\_

Date of the accident: (YYYY / MM / DD) \_\_\_\_\_

Full Address: \_\_\_\_\_

Home Telephone #: \_\_\_\_\_ Cell #: \_\_\_\_\_

### CAR INSURANCE INFORMATION

Name and Address of Your Car Insurance Company:
Policy #:
Claim #:
Name of your Insurance Adjuster:  First: _____ Last: _____
Telephone #:
Fax#:
Name of Policy Holder: <input type="checkbox"/> Self

**OTHER INSURANCE:** Do you have other insurance coverage (extended health) for chiropractic or massage therapy?

NO

YES (please complete the back of this document)

### EXTENDED HEALTH INSURANCE INFORMATION (1)

Name and Address of your EXTENDED Insurance Company:
Telephone #:
Policy #:
Name of Plan Holder:
Yearly Maximum Reimbursement for <b>Chiropractic Care</b> :
Yearly Maximum Reimbursement for <b>Massage Therapy</b> :
Have you submitted any claims to your Extended Health Insurance Co. since January 1st Y / N

### EXTENDED HEALTH INSURANCE INFORMATION (2)

Name and Address of your EXTENDED Insurance Company:
Telephone #:
Policy #:
Name of Plan Holder:
Yearly Maximum Reimbursement for <b>Chiropractic Care</b> : \$
Yearly Maximum Reimbursement for <b>Massage Therapy</b> : \$
Have you submitted any claims to your Extended Health Insurance Co. since January 1st Y / N

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# Motor Vehicle Accident Injury / Consultation

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

**PLEASE COMPLETE ALL INFORMATION**

Date of Accident: \_\_\_\_\_

Were you the driver or the passenger of the vehicle?  Driver  Passenger (front or back)

Were you wearing a seat belt?  Yes  No

Was the vehicle moving or stopped when it was hit?  Moving  Stopped

What were you attempting to do at the time of impact? (Eg. Making a left/right hand turn, changing lanes...)

\_\_\_\_\_

Did you see the vehicle coming towards you as the collision occurred (did you brace yourself for the impact?)

\_\_\_\_\_

How was the vehicle struck? (Eg. Rear-end, Head On, Side) \_\_\_\_\_

Were the airbags activated?  Yes  No

Did your head strike the windshield, side window, or did your chest strike the steering wheel? Explain \_\_\_\_\_

\_\_\_\_\_

Were you wearing glasses or a hat at the time of the accident?  Yes  No

If yes, did the impact throw them off?  Yes  No

Did you have any cuts / bruises / stitches? (Describe where?) \_\_\_\_\_

\_\_\_\_\_

How did you react to the accident? \_\_\_\_\_

\_\_\_\_\_

Were you able to get out of the car?  Yes  No Were you knocked unconscious?  Yes  No

Were you able to get out of the car on your own?  Yes  No

Were you taken to the hospital?  Yes  No If yes, how?  Ambulance  Other Means

Did they use a stretcher?  Yes  No Did they use a neck brace?  Yes  No

Was your car drivable following the accident?  Yes  No

How long did it take following the accident before you felt the pain? \_\_\_\_\_

Where did you feel the pain? \_\_\_\_\_

\_\_\_\_\_

Rate your pain on a scale of 1 to 10. (1=Mild 10=Severe)

1 2 3 4 5 6 7 8 9 10

What type of pain is it?

- Burning  Aching  Dull  Sharp  Stabbing
- Tingling  Numbness  Shooting  Cramps  Stiffness

Swelling       Other \_\_\_\_\_

Who did you consult after the accident (Eg. Chiropractor, Physiotherapist, Medical Doctor...) before coming into our office? \_\_\_\_\_

What kind of treatments or medication did you receive from them? \_\_\_\_\_

What other changes have you noticed since the accident?

- Difficulty Sleeping (number of hours now \_\_\_\_ number of hours before the accident \_\_\_\_ )
- Muscle Tension / Spasms (where?) \_\_\_\_\_
- Digestive Problems (explain) \_\_\_\_\_
- Headaches (how often?) \_\_\_\_\_
- Stiffness (where? is it constant or worse at certain times?) \_\_\_\_\_
- Limited Movements (of what body parts?) \_\_\_\_\_
- Decreased Appetite
- Irritable
- Memory Problems
- Ringing in the Ears
- Fatigue
- Visual Disturbances
- Low Back Pain

List any other changes that are not mentioned: \_\_\_\_\_

Has this problem prevented you from doing anything (going to work, hobbies, activities, sleeping, sitting, standing, walking, life in general, etc...)? Describe how these activities of daily living have been affected? Please list **anything** that you **can't** do now that you **used to be able to do** with ease and explain **why** you can't do these activities now. (Eg. Too much pain, fatigue, headaches...) \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Which activities are difficult to perform?

- Sitting                       Standing                       Walking                       Bending
- Lying Down                       Reaching Up                       Picking things up from the floor

Have you ever broken any bones or torn ligaments in the past?     Yes     No

If yes, specify: \_\_\_\_\_

Have you ever injured the present area of pain in your body in the past?     Yes     No

If yes, specify: \_\_\_\_\_

Have you ever been a recipient of Workers' Compensation Benefits?     Yes     No

If yes, specify type of injury: \_\_\_\_\_

Have you ever had a previous motor vehicle accident?     Yes     No

If yes, specify what injuries you sustained: \_\_\_\_\_

Signature: \_\_\_\_\_