BYERS CHIROPRACTIC AND MASSAGE

Car Accident History

9003 Canyon Drive
Kent WA 98030
253-852-1250

Name:_____Home:_____

Address:_____City:_____State_____Zip_____

Age:_____D.O.B._____ M / F Cell Phone: _____
SS# _____Email: _____

Emergency Contact:_____

Employers Name & Address:_____
ER Clinic: _____ ER Doctor Name: _____
ER City and State: _____ ER Treatment: _____

Nature of Accident:

Date Of Accident:_____Time:_____

City of Accident: _____ County of Accident: _____

Where were you: **a) Driver b) Passenger c) Front Seat d) Back Seat**

Who is the owner of the car you were driving? _____
Owner's phone number:_____
Owner's Place of Employment:_____
Number of people in your car: _____

Names of people in the car with you:_____

_____

Can you bring the people in the car with you for a whiplash exam?
YES (What day/time would you like? _____) NO

What direction were you headed: **a) North b) South c) East d) West**

On what street?_____

What direction was the other car headed: **a) North b) South c) East d) West**

Were your struck from: **a) Behind b) Front c) Left Side d) Right Side**

Were you knocked unconscious? **Yes No** Did you hit your head? **Yes No**

Where were you taken after the accident?_____

By Ambulance? **Yes No** What did they do for you?_____

Were the police on the scene? **Yes No** Was a report filed? **Yes No**

Do you have a copy? **Yes No**

Have you been treated by any other doctors for this injury or accident?

_____

Since the injury, are your symptoms: **Improving Getting Worse Getting Better**

Have you lost time from work? **Yes No** Date you Left: _____Returned?_____

Have you been involved in an accident in the past?_____

Describe:_____

Do you have any previous illnesses which relate to this case? **Yes** **No**

If Yes, _____

Do you notice any activity restrictions as a result of this injury? **Yes** **No**

If Yes, _____

_____

Circle **ANY / ALL** symptoms noted after the accident:

Headache	***Dizziness***	***Light bothers eyes***
Neck pain	***Head seems heavy***	***Loss of memory***
Neck stiffness	***Pins & needles in arms***	***Ears ring***
Sleeping problems	***Pins & needles in legs***	***Face Flushed***
Back pain	***Numbness in fingers***	***Buzzing in ears***
Nervousness	***Numbness in toes***	***Loss of balance***
Tension	***Shortness of breath***	***Fainting***
Irritability	***Fatigue***	***Loss of smell***
Chest pain	***Depression***	***Loss of taste***
Diarrhea	***Feet cold***	***Hands cold***
Loss of taste	***Hands cold***	***Stomach upset***
Constipation	***Cold sweats***	***Fever***

Other: _____

Your AUTO Insurance Information:

Insurance Name:_____Phone:_____ Ext:____

Policy # _____Claim# _____

Do you have Personal Injury Protection? Y N

The Other Car's AUTO Insurance Information:

Insurance Name:_____Phone:_____ Ext:____

Policy # _____Claim# _____

Your HEALTH Insurance Information

Insurance Name: _____ Phone: _____

Policy # _____

Your Attorney Name: _____ Phone: _____

Insurance: *We accept all auto accident plans and most often we have checked on your insurance before your initial visit with us. In the event your insurance or your 3rd party insurance does not pay your quoted benefits, I authorize Byers Chiropractic & Massage to file a formal written complaint to the insurance commissioner on my behalf. I understand if a complaint does not result in payment of my balance, I am responsible for the balance to be paid by myself. If I am a 3rd party claim, non-PIP, I have chose not to use my health insurance to pay for my medical bills.If your case is or will be a 3rd party, a lien will be filed and will be charged to the 3rd party insurance carrier.*

Consent To Treat*: I also understand that no cures are promised (or implied) and any risks regarding care at this office will be explained to me upon request. I now authorize the attending Dr to proceed with any necessary information and I agree with them by signing below.*

Consent to Treat a Minor: *By signing below I give consent for my minor child to be treated by Byers Chiropractic and their providers.*

PIP application: *I authorize Byers Chiropractic &Massage to request my PIP application to be faxed to their office. I further authorize Byers Chiropractic & Massage to request my PIP decline letter from my insurance company. If a PIP claim has not been opened at the time insurance is verified, I authorize Byers Chiropractic to open a PIP claim.*

Signature:_____Date:_____