AZ Multicare Ltd. Chiropractic Office 16700 N. Thompson Peak Pkwy., Ste. 260 Scottsdale, AZ 85260 phone 480-991-5555 fax 480-948-8295

Auto Accident Questionnaire

Date of Accident: _____ Hour: _____AM _____PM _____

Specific Location of Accident: _____

Describe in detail, in your own words, how the accident happened:_____

_____

In the accident: Were you the ☐ Driver ☐ Passenger ☐ Pedestrian ☐ Other? _____

Did your car strike the other vehicle? ☐Yes ☐No **Did the other car strike your car? ☐Yes ☐No**

Were you struck from: ☐ Behind ☐ Front ☐ Side Impact ☐ Driver's Side ☐ Passenger's Side

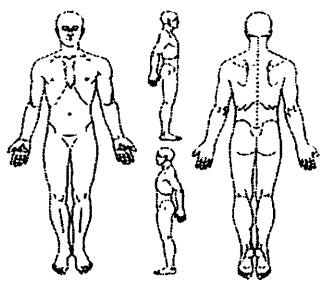
Were traffic citations issued to: ☐ You ☐ the Driver of Your Car ☐ the Driver of the Other Car ☐ No Citations Given

Was your car heading: ☐ North ☐ South ☐ East ☐ West on _____ (Street/Highway)

Was the other heading: ☐ North ☐ South ☐ East ☐ West on _____ (Street/Highway)

Please mark on the diagram to the right the following symbols as they relate to the patients' symptoms:

SS = spasms ST = stiffness
DP = dull pain SP = sharp pain
SH = shooting pain TI = tingling
NU = numbness O = Other



CHECK ANY OF THE FOLLOWING SYMPTOMS YOU HAVE NOTICED SINCE THE ACCIDENT:

☐ Headache	☐ Middle Back Pain	☐ Lower Back Pain	☐ Ears Ring
☐ Neck Pain	☐ Chest Pain	☐ Lower Back Stiffness	☐ Buzzing in Ears
☐ Neck Stiffness	☐ Bruised Chest	☐ Radiating Pain	☐ Dizziness
☐ Sleeping Problems	☐ Bruising Anywhere	☐ Tingling in Legs	☐ Loss of Smell
☐ Depression	☐ Blurred Vision	☐ Tingling in Arms	☐ Loss of Taste
☐ Anxiety	☐ Sensitivity to Light	☐ Jaw Pain	☐ Any Burns
☐ Fainting	☐ Upper Arm Pain	☐ Upper Leg Pain	☐ Any Stitches
☐ Muscle Spasms	☐ Lower Arm Pain	☐ Lower Leg Pain	☐ Any Cuts

Have you lost time from work? ☐ Yes ☐ No: If Yes, Dates: _____ to _____

Employer: _____ Employers Telephone: _____

Did you go to the hospital? ☐ Yes ☐ No: If Yes, Name of Hospital or E.R: _____

Address: _____ Date of Hospitalization: _____

Attending E.R. Doctor: _____ Treatment Given? _____

DO YOU HAVE A HISTORY OF ANY OF THE FOLLOWING DISEASES?:

Tuberculosis	☐ Yes	Lung Disease	☐ Yes	Gout	☐ Yes	Diabetes	☐ Yes
Kidney Disease	☐ Yes	Stomach/Ulcer	☐ Yes	Heart Disease	☐ Yes	Hepatitis	☐ Yes
Sciatica	☐ Yes	Blood Pressure	☐ Yes	Transfusion	☐ Yes	Polio / MS	☐ Yes
Colon Disease	☐ Yes	Stroke	☐ Yes	Cancer	☐ Yes	Bleeding	☐ Yes
Paralysis	☐ Yes	Seizures	☐ Yes	Arthritis	☐ Yes	Asthma	☐ Yes
Anemia	☐ Yes	Thyroid Disease	☐ Yes	Drug Dependence	☐ Yes	AIDS	☐ Yes

Patient Signature:_____ Date:_____

PLEASE CHECK (✓) AS MANY OF THE FOLLOWING STATEMENTS THAT APPLY TO YOUR CASE.

☐ I have medical payment (Med-Pay) benefits, either, personally or through the driver of my vehicle.
☐ I have group health insurance benefits either directly or through my spouse or parents.
☐ **I have retained an attorney.**
☐ **I have not retained an attorney.**
☐ I have the adverse or third party information available. (Insurance company of the other driver.)

PLEASE PROVIDE THE APPROPRIATE INSURANCE INFORMATION:

1) YOUR AUTOMOBILE INSURANCE CARRIER: _____

Address: _____ City: _____ State: _____ Insured: _____

Claim #: _____ Policy #: _____

Telephone: (_____) _____ Fax: (_____) _____ Adjuster: _____

2) YOUR GROUP HEALTH INSURANCE COMPANY: _____

Address: _____ City: _____ State: _____ Insured: _____

Date of Birth: _____ Policy #: _____ Group#: _____

Telephone: (_____) _____ Fax: (_____) _____

3) ADVERSE OR THIRD PARTY AUTOMOBILE INSURANCE CARRIER: _____

Address: _____ City: _____ State: _____ Claims Rep: _____

Claim #: _____ Policy #: _____ Insured: _____

Telephone: (_____) _____ Fax: (_____) _____

4) Attorney: _____ Legal Assistant: _____

Address: _____

Telephone: (_____) _____ Fax: (_____) _____

Authorization to Release Medical Information: I authorize the release of any medical information necessary to process my insurance claim (s) and also certify that all insurance information given to this clinic is correct and complete.
Request for Payment of Benefits to Provider of Care: I hereby authorize the Insurance Company/Insurance Administrator to pay by check, and for it to be mailed directly to AZ MultiCare the expense benefits allowable and otherwise payable to me under my current policy, as payment toward the total charges for professional services rendered. I have agreed to pay, in a current manner, any balance of said applicable charges. I agree that this office be given power of attorney to endorse/sign my name on any and all drafts for payment of my bill.
HIPAA Compliance
AZ MultiCare Chiropractic Office is required by law to maintain the HIPAA Notice of Privacy Practices. This notice explains our legal duties and privacy practices with respect to your protected health information. Signature below acknowledges that I have read this Notice of our Privacy Practices, Authorization to Release Medical Information & Request for Payment of Benefits to a Provider of Care A copy will be provided to me upon request.

Patient's Name: _____

Patient Signature: _____ Date: _____

Witness: _____ Date: _____