Escondido Healing Center
760-644-4228

AUTOMOBILE ACCIDENT FORM

Patient Name: _____ Today's Date: _____

Date of Accident _____ Time of Accident: _____ **AM** **PM**

Where did the accident occur: City: _____

Street: _____

Road conditions were: Wet Dry Other: _____

Did the police come to the scene? Yes No

Please describe, to the best of your ability, what happened during this accident:

_____

_____

_____

The following questions pertain to you (the patient) and the vehicle you were traveling in:

Year: _____ Make: _____ Model: _____ of the car you were in.

Were you driving? Yes No If no, where were you in the car:

_____

Were you aware of the approaching collision? Yes No

Did you lose consciousness upon impact? Yes No If yes, for how long?

_____

Were you wearing your seatbelt? Yes No If yes, was there a shoulder strap?

_____

Was your car stopped at the time of impact? Yes No
Was your airbag deployed? Yes No
If yes, was the driver's foot on the brake? Yes No

If the car was moving, how fast were you going? _____ mph.
Were you moving at a: Steady speed Gaining speed Slowing down

What was your body position at the time of impact:

Head turned right	Head straight	Looking back (Left or Right)
Head turned left	Body in straight position	Other: _____

What part of the car did the following body parts hit (if any):
Head: _____
Left/Right hip: _____
Chest: _____
Left/Right leg: _____
Left/Right shoulder: _____
Left/Right knee: _____
Left/Right arm: _____
Other: _____

Patient Name: _____

Where did you feel pain immediately after the accident? _____
List the extent of your injuries as you know them: _____
_____
_____

Did you bleed from this accident? Yes No
Did you bruise from this accident? Yes No

Hospitalized? Yes No How long _____
What was the name of the hospital? _____
Treatment given _____
Have you consulted other health professionals since your accident? Yes No
If so, what was the health professional's name?
_____ L.Ac., D.C., M.D., D.O., D.D.S.
What was the diagnosis?
_____
What treatment was given?_____
How often did/do you see this health professional?
_____

Are your work activities restricted as a result of this accident? Yes No
If yes, dates absent from work: From _____ to _____

Were X-Rays taken? Yes No If yes, what areas were X-Rayed?
_____

Circle symptoms you have noticed *since* the accident:

Headaches	Numbness in toes	Flushed face
Head feels heavy	Light bothers eyes	Cold hands
Dizziness	Ears ring	Cold feet
Fainting	Buzzing in ears	Cold sweats
Fatigue	Loss of sense of smell	Loss of balance
Neck pain	Loss of sense of taste	Upset stomach
Neck stiffness	Jaw pain	Constipation
Pins & needles in arms	Chest pain	Diarrhea
Pins & needles in legs	Shortness of breath	Tension
Numbness in fingers	Memory loss	Depression/Anxiety
Mid-back pain	Sleeping problems	Irritability
Low back pain	Fever	Nervousness

Symptoms other than those listed above:
_____
_____

Please list any of the above symptoms that you had before this accident:
_____

Since this injury are your symptoms Improving? Getting worse? No change?

The following questions pertain to the other vehicle involved in the accident:
Year: _____ Make: _____ Model: _____ of the other car.
Was the other car moving at the time of impact? Yes No
If yes, the estimated speed: _____ mph.
Were they moving at a: Steady speed Gaining speed Slowing down

Patient Name: _____

The following questions pertain to both parties auto insurance information:
Please provide the auto insurance information of the car you were traveling in:

Company name: _____

Insured's name: _____Driver's Name_____

Adjuster's name: _____

Phone #: _____ Policy #:

_____

Claim #: _____

Please provide the information on the auto insurance of the other party's vehicle:

Name of other Driver: _____

Company name: _____ In-

sured's name: _____

Adjuster's name: _____ Phone

#: _____ Policy #:

_____

Claim #: _____

Please provide your health insurance information:

Name of Insurance Company: _____

Address: _____

Group Name: _____ ID Number: _____

Name of Insured: _____

Date of Birth of Insured: _____

If you have retained an attorney, please provide their name, address and phone number:

Attorney's Name: _____

Name of Firm: _____

Attorney's Address: _____

_____

Phone Number _____Fax Number_____

Patient Signature: _____ Date: _____

Patient Name: _____

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this Acupuncture Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Escondido Healing Center will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Patient's Signature: _____

Guardian or Spouse's Signature: _____ Date_____

AFFIDAVIT OF HEALTH INSURANCE

I, _____, hereby state that I do not have any private health insurance which would cover my medical bills in excess of $_____ in relation to injuries sustained by me in a motor vehicle accident which occurred on

_____

Signature of Patient _____

Witness:_____

We will not be charging you directly. Please fill out this form so that we may bill your auto carrier for acupuncture services received as a result of your automobile accident.