

PERSONAL ACCIDENT QUESTIONNAIRE

NAME: _____ Date & Time of Accident: _____

1. How many vehicles were involved in the accident? _____

2. What was the estimated damage to the vehicle you were in? _____

3. What street or intersection were you on when the accident occurred? _____

4. What direction were you traveling in? _____

5. What city did the accident occur in? _____

6. What type of impact was the auto accident?

Rear Ended

Hit on Passenger's Side

Hit Vehicle from Behind

Other: _____

Hit on Driver's Side

7. Did your vehicle hit anything after the accident? If yes, please describe _____

8. What was your location in the vehicle?

Driver

Rear Right passenger

Front Passenger

Other: _____

Rear left passenger

9. Did you know the accident was coming?

Unaware of impending collision

Aware of impending collision and relaxed

Aware of impending collision and braced for impact

10. What type of vehicle were you in? _____

11. What type of vehicle impacted yours? _____

12. At the time of the impact, what was your vehicle doing?

Stopped

Slowing Down Gaining Speed Moving

How fast was your vehicle moving? _____

PERSONAL ACCIDENT QUESTIONNAIRE

21. Where was the headrest positioned on your body?

- | | |
|---|--|
| <input type="checkbox"/> Top of Head | <input type="checkbox"/> Mid Neck |
| <input type="checkbox"/> Middle of Head | <input type="checkbox"/> Shoulder Blades |
| <input type="checkbox"/> Base of Head | <input type="checkbox"/> Don't Recall |

22. Were you wearing a restraint belt? No Yes, what type?

- | | |
|--|---------------------------------------|
| <input type="checkbox"/> Shoulder & Lap belt | <input type="checkbox"/> Booster seat |
| <input type="checkbox"/> Shoulder Belt | <input type="checkbox"/> Don't Recall |
| <input type="checkbox"/> Baby car seat | |

23. Did you slide out of your seatbelt during the accident? Yes No Partially

24. What was damaged in your vehicle? (Circle all that apply)

- | | | |
|---|---|---|
| <input type="checkbox"/> Windshield | <input type="checkbox"/> Rear bumper | <input type="checkbox"/> Mirror |
| <input type="checkbox"/> Steering wheel | <input type="checkbox"/> Front bumper | <input type="checkbox"/> Knee bolster |
| <input type="checkbox"/> Dashboard | <input type="checkbox"/> Front left door | <input type="checkbox"/> Trunk |
| <input type="checkbox"/> Seat frame | <input type="checkbox"/> Front right door | <input type="checkbox"/> Completely totaled |
| <input type="checkbox"/> Side window | <input type="checkbox"/> Back left door | |
| <input type="checkbox"/> Rear window | <input type="checkbox"/> Back right door | |

25. Choose the items that dented inward during the accident:

- | | |
|--------------------------------------|------------------------------------|
| <input type="checkbox"/> Floorboards | <input type="checkbox"/> Dashboard |
| <input type="checkbox"/> Side door | <input type="checkbox"/> None |

26. Choose the doors that would not open as a result of the accident:

- | | |
|--------------------------------------|-------------------------------------|
| <input type="checkbox"/> Front left | <input type="checkbox"/> Rear left |
| <input type="checkbox"/> Front right | <input type="checkbox"/> Rear right |

27. Did you go to the hospital because of your accident? Yes No

If No, Where did you go?

- | | |
|---------------------------------|---------------------------------------|
| <input type="checkbox"/> Home | <input type="checkbox"/> Work |
| <input type="checkbox"/> School | <input type="checkbox"/> Other: _____ |

If you went to the hospital after your accident, answer the following questions:

28. How did you get to the hospital?

- | | |
|--|---------------------------------------|
| <input type="checkbox"/> Drove self | <input type="checkbox"/> Ambulance |
| <input type="checkbox"/> Friend | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Family Member | |

PERSONAL ACCIDENT QUESTIONNAIRE

29. What was the name of the hospital? _____

30. Were you hospitalized overnight? _____

31. Circle what you were prescribed at the hospital

Pain medication Muscle relaxers Neck brace

32. Did you receive any stitches for any cuts at the hospital? _____

33. Were x rays taken at the hospital? No Yes

If x-rays were taken, of what body part(s)?

<input type="checkbox"/> Skull	<input type="checkbox"/> Leg
<input type="checkbox"/> Neck	<input type="checkbox"/> Knee
<input type="checkbox"/> Upper / Mid back	<input type="checkbox"/> Foot
<input type="checkbox"/> Low back	<input type="checkbox"/> Shoulder
<input type="checkbox"/> Pelvis	<input type="checkbox"/> Arm
<input type="checkbox"/> Hips	<input type="checkbox"/> Other: _____

34. Was any MRI or CT films taken at the hospital? No Yes, what part of body?

To any insurance company with coverage applicable to my claim(s) and to any attorney representing me:

ASSIGNMENT OF BENEFITS

IN CONSIDERATION of the willingness of **Lake Norman Health and Wellness, PA** to treat me on credit without demand for payment at the time services are rendered, I hereby agree and stipulate as follows:

I irrevocably assign to **Lake Norman Health and Wellness, PA** any proceeds or compensation that I am or may become entitled to receive as a result of injuries that occurred on _____ to the extent of the chiropractic services rendered. I make this agreement without prejudice to any rights I may have to prosecute legal claims against any part who may be liable for my injuries, but I hereby authorize and instruct you to pay directly to **Lake Norman Health and Wellness, PA**, from any disability benefits, medical payments benefits, liability benefits, health and accident benefits, workers compensation benefits, judgments, settlements, or proceeds of any kind that would otherwise be payable to me, such sums as are due or may become due to **Lake Norman Health and Wellness, PA** for services rendered.

I appoint **Lake Norman Health and Wellness, PA** as my attorney in fact to affix my name as an endorsement upon the reverse of any check or draft upon which I am a named payee and to deposit said check or draft and apply the proceeds to any unpaid balance I may have with **Lake Norman Health and Wellness, PA**.

I authorize **Lake Norman Health and Wellness, PA** to release to any insurer with applicable coverage or to my attorney or successor attorney any information regarding my injuries, prior medical history, or treatment as may be necessary to facilitate collection of proceeds under this agreement.

I acknowledge that I remain personally liable for the total amount due to **Lake Norman Health and Wellness, PA** for services rendered, including any balance remaining after the application of insurance payments and settlement or judgment proceeds. If **Lake Norman Health and Wellness, PA** is required to take legal action against me to recover any unpaid balance on my account, I agree to reimburse **Lake Norman Health and Wellness, PA** for its costs of recovery, including reasonable attorney's fees.

Patient

Date

Witness

NOTICE OF LIEN

Pursuant to N.C.G.S. 44-49 and 44-50, **Lake Norman Health and Wellness, PA** hereby asserts and gives notice of a lien upon any sums recovered for personal injury in any civil action and also upon all funds paid to the above-named patient in compensation for or settlement of injuries sustained, whether in litigation or otherwise.

Lake Norman Health and Wellness, PA hereby requests that if its claim is not paid in full from the foregoing proceeds, a full disclosure and accounting or proceeds be provided in conformity with N.C.G.S. 44-50.1 **Lake Norman Health and Wellness, PA** agrees to be bound by any confidentiality agreements regarding the contents of the accounting.

Lake Norman Health and Wellness, PA
Dr. Akiba J. Green, President

By: _____