AUTOMOBILE ACCIDENT INFORMATION

Name:____SS#______________________________

Accident Date ________________________Time __________AM/PM

Accident Location:____

Were you the ( ) Driver ( ) Passenger front seat ( ) Passenger back seat ( ) Pedestrian

Were you struck from ( )Front ( ) Back ( ) Right side ( ) Left side

Were you wearing a seat belt? ( ) YES ( ) NO

Was an air bag deployed? ( ) YES ( ) NO

Did any part of your body come in contact with any part of the automobile?_____ if so, please describe____

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Were you taken to the hospital? ( ) YES ( ) NO If so by ( ) Ambulance ( ) Yourself ( ) Other

Were X-rays taken? ( ) YES ( ) NO

Did you require an overnight stay in the hospital? ( ) YES ( ) NO

Did you lose any time from work because of your injuries? ______if so, list dates_______________

Please describe your injuries____

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INSURANCE INFORMATION

Name of your auto insurance carrier______________________________ Phone #__________________

Insurance Policy # or Claim #____

Address of your insurance carrier____

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Do you have an attorney that has advised you in regards to this accident? ( ) YES ( ) NO if so, please list your attorney's name and address.____

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I understand and agree that health and accident insurance policies are a arrangement between an insurance carrier and myself. Buerker Chiropractic Office will prepare any necessary reports and forms to assist me in making collection from the insurance company. Any amount authorized to be paid directly to Buerker Chiropractic will be credited to my account. I understand and agree that all services rendered are charged directly to me and that I am personally responsible for payment.

_______________________________________ _______________________________

PATIENT'S SIGNATURE DATE

_______________________________________ _______________________________

GUARDIAN'S SIGNATURE (if minor) DATE