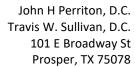


Auto/ Personal Injury Related Accident

John H Perriton, D.C. Travis W. Sullivan, D.C. 101 E Broadway St Prosper, TX 75078

ABOUT YOU
Today's Date: Completed By (circle one): Self / Guardian / Power of Attorney
Patient Legal Name: DOB:
AUTO RELATED ACCIDENT
AUTO RELATED ACCIDENT Date of Accident: Time of Accident: AM / PM Were you the (circle one): Driver / Front Passenger / Rear Passenger Number of people in the car: Did the police come: YES / NO Was a police report filed: YES / NO Were there any witnesses: YES/ NO If a traffic violation was issued, to whom was it issued: Were you wearing your seat belt: YES / NO Did air bags inflate: YES / NO In relation to the base of your skull, where was the head rest (circle one): Above / Below / At base of skull What did your vehicle impact: Another vehicle / Other: Did any part of your body strike anything in the vehicle: YES / NO If yes, explain: Make & Model of the vehicle you were in: Name of location / street (and state) on which you were traveling: In which direction you were headed: N / E / S / W Speed of your vehicle: Did the impact to your vehicle come from: Front / Rear / Right side / Left side / Other: During impact, were you facing: Left / Right / Forward / Other: During impact, were you facing: Left / Right / Forward / Other: During impact with another vehicle: Make & Model of other vehicle: Make & Model of other vehicle: Direction other vehicle was traveling: N / E / S / W Speed of other vehicle: Direction other vehicle was traveling: N / E / S / W Speed of other vehicle: Direction other vehicle was traveling: N / E / S / W Speed of other vehicle: Direction other vehicle was traveling: N / E / S / W Speed of other vehicle: Direction other vehicle was traveling: N / E / S / W Speed of other vehicle: Direction other vehicle was traveling: N / E / S / W Speed of other vehicle: Direction other vehicle was traveling: N / E / S / W Speed of other vehicle: Direction other vehicle was traveling: N / E / S / W Speed of other vehicle: Direction other vehicle: Direction other vehicle: Direction other vehicle: Direction other
Name of Davon Completing Registration (avint)
Name of Person Completing Registration (print):
Patient / Guardian (if minor) signature: Date:



Date:



PATIENT NAME	:								Date of Birth:
AFTER INJURY									
Did the accident render you unconscious: YES / NO									
Please describe how you felt immediately after the accident:									
Have you gone to a hospital or seen any other physician: YES / NO									
If yes, when: Just after accident / Next day / 2 days plus How did you get there: Ambulance / Private transportation									
Name of hospital or doctor's office: Was he/she a: D.C. / M.D. / D.O. / D.D.S									
Describe any treatment received:									
Were X-Rays taken: YES / NO Was any medication prescribed: YES / NO									
Have you been able to work since the injury: YES / NO Are your work activities restricted: YES / NO									
Indicate the symptoms that are a RESULT of the accident:									
□ Dizziness			Difficulty	sleeping		Jaw problems			Nausea
☐ Memory lo	SS		Irritabilit			Arms/Shoulder pa	ain		Back pain
☐ Headaches			Fatigue	,		Numb hands/fing			Lower back pain
☐ Blurred vis			Tension			_	CIS	_	Back stiffness
				_		Chest pain			
☐ Buzzing in			Neck pai			Shortness of brea	tn		Leg pain
☐ Ears ringing	g		Neck stif	fness		Stomach upset			Numb feet/toes
Lying on back Sitting Standing Stretching Walking Running Working Sports Lifting Bending Pulling Kneeling Reaching	k		/A 0 0 0 0 0 0 0 0 0 0	Comfortable 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	U	2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	Painful 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3		Have you retained an attorney: YES / NO If Yes, who: Phone #: Do you have ACTIVE military status: YES / NO Do you have active Medicaid / Medicare (circle one) coverage? YES / NO
RECOVERY									
How many hour	rs are in y	our	normal w	ork / school da	y:	our recovery please vities which you are			e following: v asked to perform:
□ Standing		Dr	iving	□ Opera	ting	equipment			
☐ Sitting	П		visting			arms above head			
□ Walking			_			arms above nead			
☐ Lifting			awling	71- (
_		RE	ending	☐ Stoop	ıng				
□ Other									
Name of Perso	on Comp	leti	ng Regis	tration (print)	:				

Patient / Guardian (if minor) signature:



Patient / Guardian (if minor) signature:

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* WELLNESS CENTER	Prosper, TX 75078
ATIENT NAME:	Date of Birth:
	INJURY VERIFICATION
3 RD PARTY INSURANCE INFORMA	TION (other person's car insurance)
nsured:	
Insurance Co Name:	Ins Co Phone #:
Adjuster:	Adjuster Phone #:
Claim #:	
OFFICE USE ONLY: (PATIENTS <u>DO NOT</u> CO	OMPLETE)
Has insurance accepted liability:	
Medical Claims Address:	
Email:	
Date of Accident on file:	
	SURANCE (your car insurance)
Insured's Name:	Insured DOB:
	Ins Co Phone#:
Policy #:	Claim #:
Medical Adjuster Name:	Adjuster Phone #:
OFFICE USE ONLY:	
Medical Claims Address:	
Email:	
TO THE PATIENT: I understand tha	at although Prosper Chiropractic & Wellness Center will file
•	al responsibility for my care and will pay any portion not
covered by insurance. I understan	d I AM RESPONSIBLE FOR ALL CHARGES INCURRED.
	print):

Date:



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PATIENT NAME: Date of Birth:

SIGNATURE ON FILE

I authorize use of this form on all my insurance submissions.

I authorize release of information to all my Insurance Companies.

I understand that I am responsible for all my bills regardless of third-party liability.

I authorize my doctor to act as my **agent** in helping me obtain payment from my insurance companies.

I **permit** a copy of this authorization to be used in place of the original.

I authorize payment directly to my doctor.

By my signature I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. I recognize that *Prosper Chiropractic & Wellness Center* physicians and providers are offering me an additional service by filing my insurance claims and waiting for their payment. I am aware that *Prosper Chiropractic & Wellness Center* providers reserve the right to revoke this assignment and demand payment for services rendered should difficulties arise in collecting payment form my insurance company, or if for any reason my care is discontinued at this office.

Name of Person Completing Registration (print):	
Patient / Guardian (if minor) signature:	Date: