**Maryland Spine Care**
**517 Main Street**
**Reisterstown MD 21136**
**P- (410)833-3038  F- (410)833-3039**

# Auto Accident Questionnaire

*Please complete all of the following questions regarding your accident. These details are very important.*

Full name _____Today's date _____/ _____/_____

Date of Birth: _____/_____/_____

Date of accident: _____/_____/_____ Time of Accident: ___:_____ am / pm

Type of vehicle(s) involved _____

Location of accident:  (intersection/street):  _____

City _____ State _____ Zip Code _____

Police Report Filed?  Yes  No  Do you have a copy?  Yes  No

**Explain the accident in your own words:**

_____

_____

_____

_____

**Draw Accident:**

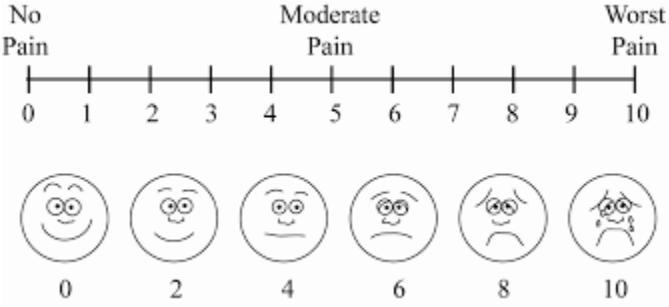
1. **What area(s) ARE OR WERE painful since the accident?** (Check ALL areas.)
   □ Neck □ Upper back □ Mid-back □ Lower back □ Shoulder (left / right)

   □ Elbow (left / right) □ Wrist (left / right) □ Hand (left / right) □ Hip (left / right)

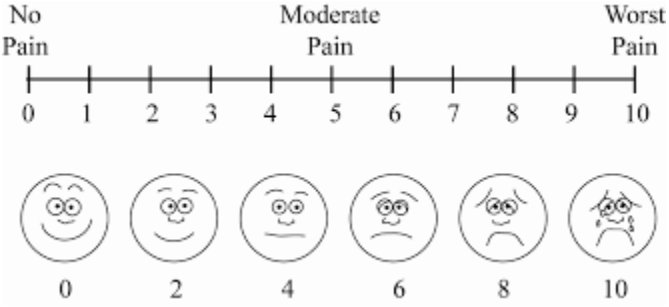
   □ Knee (left / right) □ Ankle (left / right) □ Foot (left / right) □ Headaches

   Other: _____

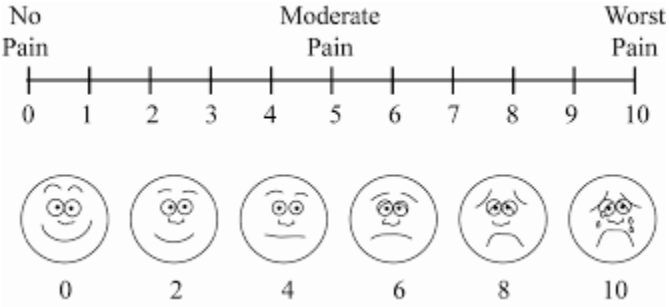
**Primary Problem _____**



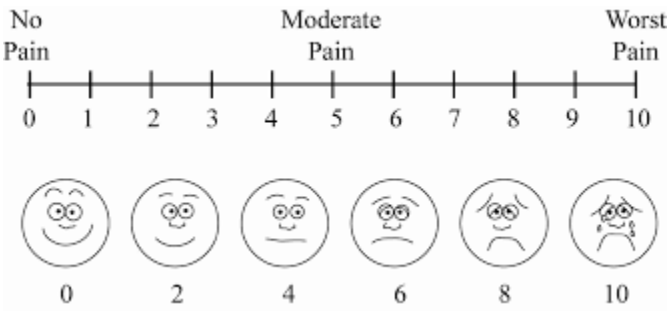

**Next Problem _____**



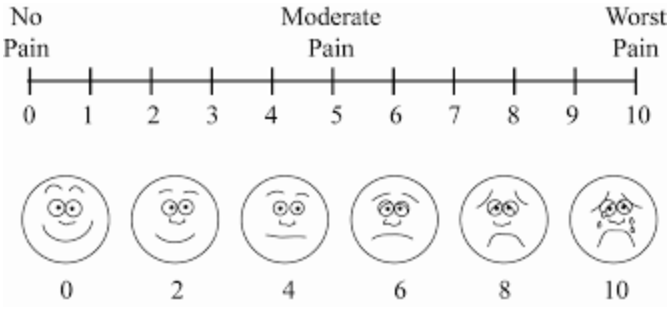

**Next Problem _____**



**Next Problem _____**




**Next Problem _____**




2. **Other symptoms: (circle)**

Dizziness Light-headedness Nausea Visual problems
Memory loss Vomiting Urinary problems Constipation Diarrhea
Bleeding Paralysis Sleeplessness Restlessness Forgetful/foggy
Numbness Tingling Disorientation Ringing /buzzing in ears
Decreased concentration Other - _____

3. **After the accident, when did your symptoms begin? (circle)**
Immediately Couple of hours later Half a day later The next day 2 days later
Other: _____

4. **Seat belt on?** Yes No **Shoulder harness on?** Yes No **Seat?** Upright Reclined

5. **Visibility?** Excellent Good Poor **Road Surface?** Wet Dry Icy Snow

6. **How has your pain progressed since the accident?** Worse Same Improved

7. **Where were you in the vehicle?** Driver Front passenger
Back left (behind driver) Back right Other: _____

8. **How was your head positioned at the time of the accident?**

Turned right Turned left Straight ahead Other : _____

9. **If you were the driver, where was your right foot when the accident happened?**
On the brake On the gas pedal Resting on the floor Bracing

10. **How was your body positioned at the time of the accident?**
Straight Turned left Turned right Upright Slouching Reclining

11. **What part of the car in which you were sitting was hit? (circle all that apply)**

Front Rear Drivers side Passenger side Drivers Corner Passenger Corner

12. **Airbags deployed?** Yes No **If yes which ones?** Front Side

13. **During the accident, how did your body move?** (Circle ALL that apply.)
Violently jolted in seat Thrown - forward / backward Thrown - left / right

Were you aware that the accident was about to happen? Yes No
Were you braced for the impact? Yes No

14. **Did any part of your body (INCLUDING YOUR HEAD) strike anything in/on the car?** (Driver or passenger door/ window, windshield, dashboard, console, etc.)
A. Body part _____ struck _____
B. Body part _____ struck _____
C. Body part _____ struck _____

15. **Did you lose consciousness?** Yes No If Yes, for how long? _____
Do you/did you have amnesia? Yes No

16. **Was your car stopped at the time of the accident?** Yes No
If No, what was your estimated speed? _____
The car was: Slowing down Gaining speed Driving at a steady rate
Did the accident push/move your car? Yes No
If Yes, in which direction? Forward Backward Sideways Diagonally
How far were you pushed? (approx.) _____
If pushed, did your car strike another car/object? Yes No
If Yes, what?_____

17. **Were you seen at a hospital?** Yes No **Date** _____/_____/_____
Hospital name _____
How did you get to the hospital? _____
Were X-rays taken? Yes No
Medications prescribed at the hospital:
Muscle relaxant Anti-inflammatory Painkiller
Other medication(s) _____
Time off from work? Yes No If Yes, from _____ to _____

18. **Please list any other doctors/healthcare providers seen since the accident**

Name: _____ Date of Visit: _____

Address: _____

Phone: _____

Name: _____ Date of Visit: _____

Address: _____

Phone: _____

19. **Previous accidents or significant injuries to areas injured in this accident**

A. Type of accident : _____

Date: _____

Body Area(s) injured: _____

Did you recover completely? Yes □ No If No, explain:

_____
_____
_____

B. Type of accident : _____

Date: _____

Body Area(s) injured: _____

Did you recover completely? Yes □ No If No, explain:

_____
_____
_____

20. **Were any of the areas injured in the present accident symptomatic before the accident?**

Yes No If Yes, explain:

_____
_____
_____

How much damage was done to your vehicle?

Check one:

- □ $1,000 or less
- □ $1,000 - $2,000
- □ $2,000 - $3,000
- □ More than $3,000
- □ Vehicle Total Loss

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**Office Policy:** If you are filling out this Auto Questionnaire it means you have been involved in an auto accident. This office will bill your auto insurance for our services provided to you. Any remaining balance, or if you have no PIP coverage the full balance, will be billed directly to you and/or your attorney. It is at our discretion as to whether any other insurance including you major medical of any kind will be billed and/or accepted as payment for services provided pertaining to your auto accident case.

**Print name**: _____

**Signature**: _____ **Date**: _____/_____/_____

**Your Car Insurance Carrier:** _____

**Policy Holder:** _____

**Do you have Personal Injury Protection (PIP) Coverage? Yes No**

**Claim Number:** _____

**Policy Number:** _____

**Insurance Adjuster's Name:** _____

**Phone:** _____ **Fax:** _____

**Billing Address:** _____

_____

**Attorney Name:** _____

**Phone:** _____ **Fax:** _____

*I agree that all of the information provided above and on prior pages is correct and true to the best of my knowledge:*

**Print name**: _____

**Signature**: _____ **Date**: _____/_____/_____

**Maryland Spine Care**
**Patrick Ingram, DC**
517 Main Street
Reisterstown, MD. 21136
Phone 410.833.3038 Fax 410.833.3039

## Authorization To Pay Physician/ Lien

I hereby authorize the _____ Auto Insurance Company, under its PIP (Personal Injury Protection) or any other policy provisions, to pay by check, made out and mailed directly to:

***Maryland Spine Care 517 Main Street Reisterstown, MD. 21136***

the medical expense benefits allowable, and otherwise payable to me, under my current insurance policy, or any third party insurance, as payment toward total charges for professional services rendered. This payment will not exceed my indebtedness to the above mentioned assignee, and I agree to pay, in a current manner, any balance, of said professional service charges over and above this insurance payment. If my current policy or third party policy prohibits direct payment to the doctor, then I hereby authorize the insurance company listed above to make the check payable to ***Maryland Spine Care*** and mail it to the above address. This is a direct assignment of my rights and benefit under my policy or any third party policy.
I also authorize my attorney to pay Maryland Spine Care/ Patrick Ingram, DC directly, any outstanding debt for services provided in relation to said accident. This authorization is intended to ensure the Maryland Spine Care's/ Patrick Ingram, DC's bill will be paid before I receive any proceeds from a settlement in regards to said accident. A photocopy or fax shall be considered as effective and valid as the original.
In addition, I hereby authorize the release of any information pertinent to my case to be sent to/from Maryland Spine Care & to/from any insurance company, third party of any sort, adjuster, or attorney involved in this case.

Claim # _____ Date of Accident: _____ / _____ /_____

Signature of Claimant _____ Date _____ / _____ /_____

Print Name _____

Signature of Doctor _____ Date _____ / _____ /_____

Print Name _____

Signature of Attorney (if applicable), or authorized representative

_____ Date _____ / _____ /_____

Print Name _____

**Maryland Spine Care**

Dr. Patrick Ingram, DC

517 Main Street

Reisterstown, Maryland 21136

www.marylandspinecare.com

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# Authorization to Release/Receive Medical Records

Patient Name: _____

Date of Birth: _____/_____/_____

This authorization allows Maryland Spine Care to **release *all* records** you may have on file with us. This authorization will also allow us to **receive *all* records** from other parties.

Patient Signature: _____

Date: _____/_____/_____