AUTO ACCIDENT FORM
Family Chiropractors of Montclair
39 Watchung Plaza
Montclair, N J 07042

Name: _____Date of Birth: _____ **DATE**: _____

Status: □ Single □ Married □ Widowed □ Divorced □ Child Sex: Male / Female

Height: _____ **Weight:** _____ **Blood Pressure:** _____/_____

Address: _____

City: _____ State: _____ Zip: _____

SS#: _____

Home Phone: _____ Cell Phone: _____

Email: _____

Occupation: _____ Employer: _____

Work Phone: _____ Ext. _____

(The U.S. Government is now requiring that we supply the following information)

Ethnicity: (Please Circle One)

Hispanic or Latino	**Not** Hispanic or Latino

Race: (Please Circle)

White	American Indian/ Alaskan Native	Asian
Black/African American	Native Hawaiian/ Pacific Islander	Two or more

Preferred Language:

□ English □ Spanish □ Italian
□ Mandarin □ French □ Japanese
□ Cantonese □ German □ Other: _____

Smoking Status:

□ Smoke Every Day
□ Smoke Some Days
□ Former Smoker
□ Never Smoked

Have you been diagnosed with: (Please Circle)

Asthma?	Diabetes? Type I ☐ Type II ☐	High Blood Pressure? _____/_____ (at high point)	No

Insured Name: _____ Insurance Company: _____

Insurance Company Address: _____

_____

Claim Adjuster: _____ Phone #: _____ Ext: _____

POLICY #: _____

CLAIM #: _____

1. What was the date and time of the accident? _____

2. Was a police report written up for this accident? □ Yes □ No

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

3. In what city and State did the accident occur? _____

4. Describe the accident in your own words: What Happened? _____

_____

_____

_____

5. What was your position in the car? □ Driver □ Passenger

If Passenger, where were you sitting? □ Front □ Right Rear □ Left Rear

6. Was your vehicle struck by another vehicle? □ Yes □ No

Angles of impact… First Collision: □ Front □ Back □ Left □ Right
If Second Collision: □ Front □ Back □ Left □ Right

7. What type of vehicle were you in? _____

8. What type of vehicle impacted yours? _____

9. Were you wearing a seat belt? □ Yes □ No

10. Did you brace for impact? □ Yes □ No … □ I braced with my hands □ I braced with my feet

11. Which way were you facing at the time of the impact? □ Straight ahead □ Left □ Right

12. Did you strike another vehicle at time of impact? □ Yes □ No
If yes, please specify what part of your body struck what
□ Steering Wheel _____ □ Dashboard _____
□ Windshield _____ □ Roof _____
□ Left Side Door _____ □ Right Side Door _____
□ Other _____

13. Immediately after the accident, how did you feel? □ Dizzy/Dazed □ Disoriented □ Unconscious
□ Nervous □ Nauseous □ Upset □ Weak
□ Other: _____

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

15. During and after the crash, what happened to your vehicle? (Select all that apply)
□ Kept Going Straight □ Spun Around
□ Kept going but was hit by car in front □ Spun around and hit stationary object
□ Was hit by another vehicle □ Hit a stationary object

16. Did you lose consciousness during the accident? □ Yes □ No

17. Did your head hit anything during the accident? □ No □ Yes, describe: _____

18. Did your face hit anything during the accident? □ No □ Yes, describe: _____

19. Did your shoulders hit anything during the accident? □ No □ Yes, describe: _____

20. Did your neck hit anything during the accident? □ No □ Yes, describe: _____

21. Did your chest hit anything during the accident? □ No □ Yes, describe: _____

22. Did your hips hit anything during the accident? □ No □ Yes, describe: _____

23. Did your knees hit anything during the accident? □ No □ Yes, describe: _____

24. Did your feet hit anything during the accident? □ No □ Yes, describe: _____

25. What was damaged in your vehicle? (Select all that apply)

□ Windshield	□ Rear bumper	□ Mirror
□ Steering Wheel	□ Front Bumper	□ Knee bolster
□ Dashboard	□ Trunk	□ Back Right door
□ Seat frame	□ Front Left door	□ Completely Totaled
□ Side Window	□ Front Right door	
□ Back Window	□ Back Left door	

26. **Did you go to the hospital?** □ Yes □ No If yes, for how long? _____

When? □ At time of accident □ Next day
How did you get there? □ Ambulance □ Police Car □ Private Transportation

Name of Hospital: _____

Attended by Dr. _____

27. What treatment was given? **(Check all that apply)**

□ None □ placed in a cervical collar □ x-rayed □ given stitches □ Bandaged □ Medication

List the Medications Given: _____

□ Given instructions regarding concussions □ given instructions regarding sprains/strains

□ Physical Therapy □ instructed to call an Orthopedic surgeon □ instructed to call a private physician

□ Referred to this office for treatment: □ Other _____

28. If you were x-rayed at the hospital, check where on your body:

□ Neck □ Mid-Back □ Lower Back □ Other: _____

29. Have you seen any other doctors as a result of this accident? □ Yes □ No

If yes, whom? _____

30. Additional Comments: _____

_____

_____

31. List all surgical procedure you have had: _____

_____

32. Have you ever been hospitalized (other than above surgeries & accident)? □ Yes □ No

If yes, why? _____

33. **INDICATE IF ANY FAMILY MEMBERS HAVE THE FOLLOWING (and what type, if applicable):**

□ Rheumatoid Arthritis □ Diabetes:_____ □ Lupus □ Other: _____
□ Heart Problems □ Cancer: _____ □ ALS

34. For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" column.

Past	Present	Past	Present	Past	Present
□	□ Headaches	□	□ High Blood Pressure	□	□ Diabetes
□	□ Neck Pain	□	□ Heart Attack	□	□ Excessive Thirst
□	□ Upper Back Pain	□	□ Chest Pains	□	□ Frequent Urination
□	□ Mid Back Pain	□	□ Stroke	□	□ Smoking/Tobacco Use
□	□ Low Back Pain	□	□ Angina	□	□ Drug/Alcohol Dependance
□	□ Shoulder Pain	□	□ Kidney Stones	□	□ Allergies
□	□ Elbow/Upper Arm Pain	□	□ Kidney Disorders	□	□ Depression
□	□ Wrist Pain	□	□ Bladder Infection	□	□ Systemic Lupus
□	□ Hand Pain	□	□ Painful Urination	□	□ Epilepsy
□	□ Hip Pain	□	□ Loss of Bladder Control	□	□ Dermatitis/Eczema/Rash
□	□ Upper Leg Pain	□	□ Prostate Problems	□	□ HIV/AIDS
□	□ Knee Pain	□	□ Abnormal Weight Gain/Loss		
□	□ Ankle/Foot Pain	□	□ Loss of Appetite	**For Females Only**	
□	□ Jaw Pain	□	□ Abdominal Pain	□	□ Birth Control Pills
□	□ Joint Pain/Stiffness	□	□ Ulcer	□	□ Hormonal Replacement
□	□ Arthritis	□	□ Hepatitis	□	□ Pregnancy
□	□ Rheumatoid Arthritis	□	□ Liver/Gall Bladder Disorder		
□	□ Cancer	□	□ General Fatigue		
□	□ Tumor	□	□ Muscular Incoordination		
□	□ Asthma	□	□ Visual Disturbances		
□	□ Chronic Sinusitis	□	□ Dizziness		
□	□ Other:_____				

35. List all the over-the-counter medications you are currently taking:

_____

36. Please list all **Prescription** Medications you are currently taking:

Check here if not taking any medications: ☐

Medication: i.e. Lipitor	**# of MD refills issued?**	**Quantity of Pills per Refill:**	**Strength:** i.e. 10 mg	**Dose Form:** i.e. Capsule	**MD's instruction:** i.e. 1 per day

37. **Are you allergic to any medicines? Please list each drug on a new line:**

Check here if you do not have any medicinal allergies: ☐

Name of Drug: i.e. penicillin	**Symptom if taken:** i.e. headache

CHIEF Complaints or Symptoms:

☐ **Neck Pain** ☐ none ☐ left shoulder ☐ left arm ☐ left forearm ☐ left hand
(Check off the areas that the pain runs into from the neck) ☐ right shoulder ☐ right arm ☐ right forearm ☐ right hand

☐ **Headache**
☐ **Migraine Headaches** ☐ **Ringing in Ears**
☐ **Jaw Pain** ☐ **Upper Back Pain**

☐ Dizziness ☐ Nervousness ☐ Fatigue ☐ Anxiety
☐ Depression ☐ Excessive Irritability ☐ Fear of driving in car ☐ Loss of concentration
☐ Jaw clenching ☐ Grinding teeth at night ☐ Nightmares ☐ Difficulty sleeping at night

☐ **Low Back Pain** ☐ none ☐ buttocks ☐ left buttock ☐ left thigh ☐ left knee ☐ left foot
☐ right buttock ☐ right thigh ☐ right knee ☐ right foot

□ **Hip Pain** □ Left □ Right □ Bilateral
□ **Knee Pain** □ Left □ Right □ Bilateral
□ **Foot Pain** □ Left □ Right □ Bilateral

Numbness:

□ Left Hand □ Left Upper Arm □ Right Hand □ Right Upper Arm
□ Left Foot □ Left Leg □ Right Foot □ Right Leg

Additional Symptoms and Complaints: _____

Have you lost any time from work due to your injuries? □ Yes □ No

If yes, please give dates: _____

Type of employment: _____

Have you had previous injuries or accidents? □ Yes □ No

Description of previous Accident: _____

Description of previous injuries: _____

Is there any residual pain from the previous injury? □ Yes □ No

How much better did you feel prior to your current condition? (1-100%) _____

(October-March Only):

38. Have you had a flu shot this year?

□ Yes □ No □ I Will Be Getting One

If No, Why:

□ Had Bad Reaction in the Past
□ I Got the Flu from the Shot
□ I am Philosophically Opposed/ I Choose Not to Get One

PLEASE READ BEFORE SIGNING

I understand that Family Chiropractors of Montclair is permitted by law to use my personal health information to facilitate payment of any fees and expenses. Family Chiropractors of Montclair has agreed to assist me in billing my auto insurance and any and all other applicable collateral sources. Although the practice will await their payment, I agree I am fully and personally responsible for all fees I incur in connection with service rendered for the purpose of today's encounter as well as any future services.

I HAVE READ THE ABOVE INFORMATION AND CERTIFY IT TO BE TRUE AND CORRECT. I HEREBY AUTHORIZE FAMILY CHIROPRACTORS OF MONTCLAIR TO PROVIDE ME WITH CHIROPRACTIC CARE IN ACCORDANCE WITH THE STATE'S STATUES.

Patients Signature:_____ Date: _____

HIPPA FORM

We are required by State and Federal Law to maintain the privacy of your patient file and the protected health information therein. We are also required to provide you with this notice of our privacy practices with respect to your health information. We are further required by law to abide by the terms of this notice while it is in effect.

We reserve the rights to alter or amend the terms of this privacy notice. IF changes are made to our privacy notice we will notify you, in writing, as soon as possible following the changes. Any change in our privacy notice will apply for all of your health information in our files.

f you have a complaint regarding our privacy notice, our privacy practices, or any aspect of our privacy activities, you should direct your complaint to:

Dr. Luis Mizraji. Privacy Officer
If you would like further information about our privacy policies and practices, please contact:

Dr. Luis Mizraji. Privacy Officer
You also have the right to lodge a complaint with the Secretary of the Department of Health and Human Services. If you lodge a complaint with this office or with the Secretary, your care will continue and you will not be disadvantaged by this office or our staff in any manner whatsoever.
This notice is effective as of the date of execution listed below. This notice, and any alterations or amendments made here to will expire seven years after the date upon which the record was created. My signature acknowledges that I have read through this document and that upon my request I have received a copy of this notice for my personal records.

_____	_____	_____
Name (please print)	Signature	Date

If you are a minor, your parent or guardian must sign or in the event of other representation issues, please have the following executed by the appropriate representing party.

_____	_____	_____
Personal Representative (please print)	Personal Representative Signature	Date