INJURY QUESTIONNAIRE FOR PERSONAL INJURY

DATE: _____

1. NAME _____
2. DATE OF ACCIDENT _____
3. WHERE DID ACCIDENT HAPPEN? _____

   _____
4. HOW DID ACCIDENT HAPPEN? _____

   _____

   _____
5. WHAT INJURIES DID YOU SUSTAIN AS A RESULT OF THIS ACCIDENT?

   _____

   _____

   _____

   _____
6. IF INVOLVED IN AN AUTO ACCIDENT, WHAT CAR WERE YOU DRIVING?

   _____
7. WAS A POLICE REPORT FILED? _____
8. WAS AN AMBULANCE CALLED? _____WERE YOU TRANSPORTED? _____

   IF SO, WHERE? _____
9. WERE YOU HOSPITALIZED? _____ Where? _____
10. WERE YOU X-RAYED AT THE HOSPITAL? _____
11. DID YOU STAY AT THE HOSPITAL OR WERE YOU RELEASED THE SAME DAY? _____
12. WERE ANY OTHER TESTS COMPLETED? _____
13. IF YOU WERE NOT HOSPITALIZED, HAVE YOU SEEN ANOTHER DOCTOR REGARDING YOUR INJURIES PRIOR TO COMING TO THIS OFFICE? _____

    IF SO, NAME OF DOCTOR: _____
14. WHERE ARE YOU EMPLOYED? _____
15. HAVE YOU LOST ANY TIME FROM WORK BECAUSE OF THIS ACCIDENT? ___

    IF SO, WHEN? FROM _____ TO _____

INSURANCE/ATTORNEY QUESTIONNAIRE FOR PERSONAL INJURY

In order to update our records and complete claims processing, we are asking that you complete this questionnaire concerning your medical benefit or insurance coverage for this personal injury.

Date: _____

Name: _____ Date of Birth: _____

Date of Injury:_____ Social Security Number:_____

Name of patient's insurance company: (Auto, Homeowners, Medical, etc).

_____

Insurance Company Address: _____

Policy Holder's Name: _____ Policy Number:_____

If you have retained an attorney, please provide the following information:

Attorney's Name: _____

Attorney's Address: _____

Attorney's Phone Number: _____

Please identify if any other party may be responsible for these injuries:

Name: _____ Phone Number: _____

Address: _____

Insurance Company: _____ Phone Number: _____

Insurance Address: _____

Policy Holder's Name: _____

Policy Number: _____ Claim Number: _____

Adjuster's Name:_____

I, _____, also hereby authorize Denton Chiropractic and Natural Health to release to my insurance company, attorney, or adjuster any information acquired in the course of my examination or treatment.

_____ _____

Signature Date

ASSIGNMENT

To facilitate the exercise of this right, I hereby request, authorize, and direct defendants, insurance companies, and/or my attorney, _____, if applicable, to

(Attorney Name)

make payment directly to Denton Chiropractic and Natural Health of 520 East Center Street, Marion, Ohio 43302, from the proceeds of any settlement or judgment made arising from my injury and/or accident dated _____ for medical benefits provided to me as a result of that accident.

I fully realize that his authorization in no way releases me of the responsibility of making payments on this account or claim for any and all outstanding bills for services rendered to me by Denton Chiropractic and Natural Health in the event I should not receive any funds from which payment could be made.

I, _____, also hereby authorize Denton Chiropractic

(Patient Name)

and Natural Health to release to my insurance company, attorney, or adjuster any information acquired in the course of my examination or treatment.

_____	_____
Patient Name	Parent, Guardian, other (if applicable)
_____	_____
Patient's Signature	Signature
_____	_____
Date	Relationship to patient
_____	_____
Witness	Date
_____	
Date	

NOTICE OF REIMBURSEMENT RIGHTS FOR PERSONAL INJURY

TO:

I, _____, attorney for _____.
(Attorney Name) (Patient Name)

agree to comply with the foregoing by remitting from the proceeds of any settlement, judgment, or award, the reasonable value of the medical benefits by Denton Chiropractic and Natural Health to my client as a result of injuries sustained as a direct and proximate result of the accident and/or injuries dated _____ to satisfy any lien rights as set forth herein.

Attorney Information:

_____

Attorney's Name (print)

_____ _____

Attorney's Signature Date

_____

Attorney's Address

_____

Attorney's Phone

Doctor Information:

_____

Doctor's Name

_____ _____

Doctor's Signature Date

Patient Information:

_____

Patient's Name

_____ _____

Patient's Signature Date