



PACIFIC SPINE & SPORTS

3 Corporate Park, Suite 168, Irvine, Ca 92606

P 949.955.2655 F 949.955.2699 pssirvine.com

Auto Accident Form

Accident and Damage Details:

Today's Date: _____

Patient First and Last Name: _____

Date of Accident: _____ Time of Accident: _____ AM/PM

Make and model of vehicle you were in: _____

Estimate of Damage: \$ _____ Impact: ___ Mild ___ Moderate ___ Severe

Accident Location (City, Streets, Freeway): _____

Did the police come to the scene of the accident? ___ Yes ___ No If yes, please provide a police report

Please mark your involvement in the auto accident: ___ Driver ___ Passenger ___ Pedestrian

Number of people in your accident vehicle: _____

Please describe to the best of your knowledge what happened during the accident: _____

Patient Vehicle Damage: ___ Totaled ___ Significant damage ___ light damage ___ no damage

Second Vehicle Damage: ___ Totaled ___ Significant damage ___ light damage ___ no damage

Third Vehicle Damage: ___ Totaled ___ Significant damage ___ light damage ___ no damage

Please describe vehicle damage: _____

What are your current symptoms? ___ Pain ___ Numbness ___ Stiffness ___ Weakness

Mark if you experienced or are experiencing any of the following symptoms due to the auto accident:

___ Confused ___ Disoriented ___ Light headed ___ Dizzy ___ Nauseated ___ Blurred vision ___ Restless

___ Ringing or buzzing in ears ___ Irritable ___ Sleeplessness ___ Difficulty in memory ___ Forgetfulness

___ Reduced tolerance to heat or cold

Patient Vehicle Type: ___ Coupe ___ Sedan ___ Van ___ Crossover ___ SUV ___ Truck ___ Motorcycle

Second Vehicle Type: ___ Coupe ___ Sedan ___ Van ___ Crossover ___ SUV ___ Truck ___ Motorcycle Third

Vehicle Type: ___ Coupe ___ Sedan ___ Van ___ Crossover ___ SUV ___ Truck ___ Motorcycle

Road Conditions: ___ Clear ___ Dark ___ Dry ___ Foggy ___ Icy ___ Wet

Road Type: ___ Asphalt ___ Concrete ___ Gravel ___ Dirt ___ Snow ___ Mud ___ Sand

Were you aware the accident was going to occur? ___ Yes ___ No

Were you wearing a seatbelt? ___ Yes ___ No

Did your airbag deploy? ___ Yes ___ No

What position was the head rest in? ___ Up ___ Middle ___ Down

What was your head position? ___ Looking straight ahead ___ Looking up ___ Looking down ___ Left level

___ Left up ___ Left down ___ Right level ___ Right up ___ Right down

What your vehicle braking? Yes No

Was your car moving? Yes No

If yes, how fast (mph)? Please circle. <5 6-10 11-15 16-20 21-30 31-40 41-50 51-60 61-70 >70

Was the second vehicle braking? Yes No

Was your car moving? Yes No

If yes, how fast (mph)? Please circle. <5 6-10 11-15 16-20 21-30 31-40 41-50 51-60 61-70 >70

Was the third vehicle braking? Yes No

Was your car moving? Yes No

If yes, how fast (mph)? Please circle. <5 6-10 11-15 16-20 21-30 31-40 41-50 51-60 61-70 >70

Collision Details and Results

First Impact: Hit by other vehicle Hit other vehicle Hit by object Hit object

Location Hit: Front Front right Front left Right side Left side Right rear Left rear

Second Impact: Hit by other vehicle Hit other vehicle Hit by object Hit object

Location Hit: Front Front right Front left Right side Left side Right rear Left rear

Body was thrown: Forward Backward Left Right

Head hit: Airbag Front windshield Rearview mirror Steering wheel Window/door

Chest hit: Airbag Steering wheel Window/door

Shoulder hit: Shoulder seatbelt Window/door Back of front seat

Knees hit: Steering wheel Door Center console

Hips hit: Back of front seat Door Center console

Hospitalized

Were you hospitalized? Yes No If yes, please answer the questions below.

Name of hospital: _____

Name of doctor: _____

When were you hospitalized? Immediately Later same day Next day Please date: _____

How were you transported to the hospital? Ambulance Life flight Private transportation

What did the hospital recommend? See clinic See doctor See orthopedist See neurologist Prescription medication

Treatment received: _____

Did you have x-rays taken? Yes No If yes, what areas?

Please describe any bodily injury that resulted from the accident: _____

I certify that the information I have given is correct to the best of my knowledge.

Signature: _____ **Date:** _____



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Auto Insurance Information

Auto Insurance Company of Patient: _____

Insured Name: _____

Phone#: _____

Fax#: _____

Address: _____

Adjustor's Name: _____

Claim#: _____

Policy#: _____

Medical Payment: Yes No

How much coverage: _____

Uninsured Motorist: Yes No

Do they need office to bill Health Insurance for denial? Yes No

Acupuncture Treatment Confirmation and Authorization#: _____

Third Party Insurance Information

Auto Insurance Company of Patient: _____

Insured Name: _____

Phone#: _____

Fax#: _____

Address: _____

Adjustor's Name: _____

Claim#: _____

Policy#: _____



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AUTHORIZATION TO RELEASE MEDICAL INFORMATION

To: _____

Address: _____

I, _____ request the following information:

X-rays History Records Diagnosis Treatment Reports Billing

Concerning my: Accident Injury Illness other: _____

To be released to: Pacific Spine & Sports
3 Corporate Park, Ste 168, Irvine, CA 92606
Phone#: 949-955-2655
Fax#: 949-955-2699

For the purpose of: _____

According to Section 123.110 of The California Health and Safety Code, these records/films must be provided within 15 days of your receipt of this notice.

<p>Date: _____</p> <p>Signature: _____</p> <p><input type="checkbox"/> Patient <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Guardian</p>
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