



### 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:** \_\_\_\_\_



### **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#: \_\_\_\_\_



**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  
14522 Myford Road, Ste. B, 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><b>Date:</b> _____</p> <p><b>Signature:</b> _____</p> <p>___ Patient ___ Spouse ___ Parent ___ Guardian</p>
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