PACIFIC SPINE & SPORTS
OC's Premier Wellness Center

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
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.

Date: _____

Signature: _____

___Patient ___Spouse ___Parent ___Guardian