220 Fort Salonga Rd Northport, NY 11768
Phone: 631.262.8505 Fax: 631.754.2909
www.northportwellnesscenter.com

Automobile Accident Questionnaire (page 1)

Please answer all questions completely.

Dear patient: This information is considered confidential. We need this information because we care enough to want to know, and your answers will help us determine if chiropractic can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. In order for us to understand your condition properly, please be as neat and accurate as possible while completing this form. Thank you.

Name: ____________ Sex: ___ Marital Status: _____ DOB: _______ Home Phone: ____________
Address: ____________ City: ____________ State: ______ Zip: ____________
Occupation: ____________ Who referred you to our office?: ____________
SSN: ____________ Business Phone: ____________ Company Name: ____________ Location: ____________
Spouse's Name: ____________ SSN: ____________ Spouse's Employer: ____________ Location: ____________

Date of Accident: ____________ Time: ________ Weather/Road Conditions: ____________

Please explain in detail how your accident happened: ____________

You were: Driver Front Passenger Rear Passenger: Right Left Middle

Make & Model Patient's Vehicle: ____________ Make & Model of Other Vehicle: ____________
Damage: *Mild* *Moderate* *Severe* *Totaled* Damage: *Mild* *Moderate* *Severe* *Totaled*

Est. Speed Patient's Vehicle: *Unknown* *Stopped* *<15mph* *15-25mph* *25-40mph* *40-65mph* *>65mph*

Wearing Seat Belt: *Yes* *No* Did airbags deploy: *Yes* *No* Loss of consciousness: *Yes* *No*

Did any part of your body strike the inside of the vehicle? *Yes* *No* If yes, please explain: ____________

Vehicle towed from scene: *Yes* *No* Police on scene: *Yes* *No* Police Report: *Yes* *No*

EMS on scene: *Yes* *No* Did you go to the hospital: *Yes* *No* Via ambulance: *Yes* *No*

Admitted to hospital: *Yes* *No* If yes, for how long: ____________

INDICATE ON THIS DIAGRAM WHAT HAPPENED

USE ONE OF THESE OUTLINES TO SKETCH THE SCENE OF YOUR ACCIDENT, WRITING IN STREET OR HIGHWAY NAMES OR NUMBERS:

1. Number each vehicle and show direction of travel by arrow: ——→[1.]> <[2.]←——
2. Use solid line to show path before accident ——→[2.]> dotted line after accident ---------[2.]>
3. Show pedestrian by: ———o
4. Show railroad by +++++++++++
5. Show distance and direction to landmarks: identify landmarks by name or number.
6. Indicate north by arrow, as: (↗)

INDICATE NORTH BY ARROW

220 Fort Salonga Rd Northport, NY 11768
Phone: 631.262.8505 Fax: 631.754.2909
www.northportwellnesscenter.com

Automobile Accident Questionnaire (page 2)

You were heading: *North* *East* *South* *West* on ______________________ (street or highway)

Other vehicle was heading: *North* *East* *South* *West* on ______________________ (street or highway)

Where did you feel pain immediately after the accident: ______________________

List the extent of your injuries as you know them: ______________________

____

____

Check symptoms you have noticed since the accident:

□ Headache	□ Dizziness	□ Depression	□ Fatigue
□ Stomach Upset	□ Light Bothers Eyes	□ Buzzing in Ears	□ Diarrhea
□ Neck Pain	□ Head Seems too Heavy	□ Loss of Memory	□ Feet Cold
□ Neck Stiff	□ Pins and Needles in Arms	□ Ears Ring	□ Hands Cold
□ Fainting	□ Sleeping Problems	□ Loss of Balance	□ Back Pain
□ Face Flushed	□ Numbness in Fingers	□ Constipation	□ Tension
□ Nervousness	□ Numbness in Toes	□ Loss of Smell	□ Fever
□ Irritability	□ Shortness of Breath	□ Loss of taste	□ Chest Pain
□ Cold Sweats	□ Pins and Needles in Toes	□ ____________	□ ____________

Where were you taken after the accident? ______________________

Hospitalized? □ Yes □ No If yes, admitted? ____________ How long? ____________

Name of Hospital: ______________________

Name of Doctors: ______________________

What treatment was given? ______________________

Was any other doctor consulted after your accident? □ Yes □ No

If so, what was the doctor's name? ____________ □ D.C. □ M.D. □ D.O. □ D.D.S.

What was the diagnosis? ______________________

What treatment was given? ______________________

How often did you see the doctor? ______________________

How long did you see the doctor? ______________________

Have you ever had any complaints in the involved area before? □ Yes □ No

If so, what were the complaints? ______________________

Before the injury were you capable of working on an equal basis with others your age? □ Yes □ No

Are your work activities restricted as a result of this accident? □ Yes □ No

Since this injury are your symptoms □ Improving □ Getting worse □ Same

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this Chiropractic Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this Chiropractic Office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Patient's Signature: ______________________

Guardian or Spouse's Signature: ______________________ Date: ____________

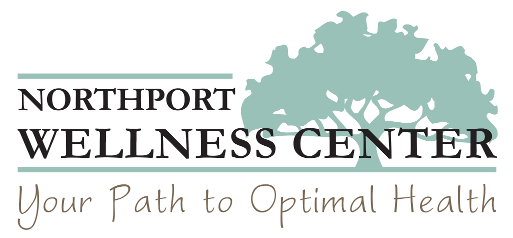
DO NOT WRITE BELOW THIS LINE

____

____

____

Patient accepted? □ Yes □ No □ Doctor's Signature ______________________



220 Fort Salonga Rd Northport, NY 11768
Phone: 631.262.8505 Fax: 631.754.2909
www.northportwellnesscenter.com

Patient No Fault Information

Patient Name: ____

Date of accident: ____

Your auto insurance company: ___________________________________

Adjusters name: ____

Phone number: ____

Address: ____

Claim #: _____________________________ Policy #: ______________________________

Deductible amount on policy: $_____________________ Amount met: $___________________

Attorney name: ____

Address: ____

Is NF2 form completed and on file? ______________ Is police report on file? ________________

*****PLEASE NOTE IF YOUR NF2 FORM IS NOT SUBMITTED TO INSURANCE COMPANY WITHIN 90 DAYS OF ACCIDENT CLAIMS WILL BE REJECTED AND DENIED.***

NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW
ASSIGNMENT OF BENEFITS FORM

(FOR ACCIDENTS OCCURRING ON AND AFTER 3/1/02)

I, ___________________________, ("Assignor") hereby assign to ___________________________, ("Assignee")
(Print patient's name) (Print hospital or health care provider name)
all rights privileges and remedies to payment for health care services provided by assignee to which I am entitled under Article 51 (the No-Fault statute) of the Insurance Law.

The Assignee hereby certifies that they have not received any payment from or on behalf of the Assignor and shall not pursue payment directly from the Assignor for services provided by said Assignee for injuries sustained due to the motor vehicle accident which occurred on __________________, not withstanding any other agreement
(Print accident date)
to the contrary.

This agreement may be revoked by the assignee when benefits are not payable based upon the assignor's lack of coverage and/or violation of a policy condition due to the actions or conduct of the assignor.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR COMMERCIAL INSURANCE OR A STATEMENT OF CLAIM FOR ANY COMMERCIAL OR PERSONAL INSURANCE BENEFITS CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, AND ANY PERSON WHO, IN CONNECTION WITH SUCH APPLICATION OR CLAIM, KNOWINGLY MAKES OR KNOWINGLY ASSISTS, ABETS, SOLICITS OR CONSPIRES WITH ANOTHER TO MAKE A FALSE REPORT OF THE THEFT, DESTRUCTION, DAMAGE OR CONVERSION OF ANY MOTOR VEHICLE TO A LAW ENFORCEMENT AGENCY, THE DEPARTMENT OF MOTOR VEHICLES OR AN INSURANCE COMPANY, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE VALUE OF THE SUBJECT MOTOR VEHICLE OR STATED CLAIM FOR EACH VIOLATION.

(Print name of Patient)	**(Signature of Patient)**
	(Date of signature)
(Address of Patient)	
(Print name of Provider)	**(Signature of Provider)**
	(Date of signature)
(Address of Provider)	

NYS FORM NF-AOB (Rev 1/2004)