

SMITH UCHC CASE HISTORY PERSONAL INJURY

Name: _____ Date: _____ Referred By: _____

Address: _____ Zip: _____

Date of Birth: _____ Age: _____ Marital Status: _____ Number of Children: _____

Pregnant: _____ Occupation: _____ Employer: _____

Employer Address: _____ Zip: _____

Claim/Policy #: _____ Date of Loss: _____ Time of Accident: _____

Auto Insurance Company of other vehicle: _____ Phone Number: _____

Driver of Vehicle in which you were injured: _____ Auto Insurance Name: _____

Name of Insured: _____ Employer's Name/Address & Phone #: _____

Your Auto Insurance Company: _____ Phone Number: _____

Address: _____ Have you reported this to your Insurance: _____

If applicable Attorney Name/Address & Phone#: _____

Location of Accident: _____

How did accident occur? Vehicle: ___ On the Job: ___ Other: ___

If not a vehicle collision, please describe the circumstances: _____

Did you report injury to your foreman or employer? Yes ___ No ___

In the accident were you the: Driver: ___ Passenger: ___ Pedestrian: ___

Year /Make & Model of the car you were in: _____

Were you struck from: Behind: ___ Right Side: ___ Left Side: ___ Front: ___ Parked: ___ Moving: ___

Approximately how far did vehicle move after impact: _____

Did your car strike the other(s) involved: Yes: ___ No: ___ Did the other car strike you: _____

Was a police report made: _____ Were you wearing a seat belt and shoulder harness: _____

Were you aware or unaware of approaching collision: _____

If driver, was your foot on: Brake: ___ Gas: ___ Clutch: ___ or nothing: ___

What were the weather conditions: _____ Road conditions: Wet: ___ Dry: ___ Other: _____

What direction was your head facing on impact: _____ Were you unconscious: _____

If so, how long: _____ Other Vehicle: Approximate Speed: _____ Size of Vehicle: _____

How far was the top of the headrest or seatback from the top of your head: _____

On what part of the auto did the following body parts hit: Head hit: _____ Chest hit: _____

Right/left shoulder hit: _____ Right/left arm hit: _____

Right/left leg hit: _____ Right/left knee hit: _____

Extent of injuries (including bleeding cuts and Bruises) as you know them: _____

Did you receive post accident treatment or hospitalization by another medical facility: Yes _____ No _____

If so, by whom: _____ Body parts that were x-rayed: _____

CHECK SYMPTOMS YOU HAVE NOTICED SINCE THE ACCIDENT

- Headache Irritability Numbness in Toes Face Flushed Feet Cold Neck Pain
- Chest Pain Shortness of Breath Buzzing in Ears Hands Cold Neck Stiff Dizziness
- Fatigue Loss of Balance Stomach Upset Sleeping Problems Head Seems Heavy
- Depression Fainting Constipation Back Pain Pins & Needles Sensitive to Light
- Loss of Smell Cold Sweats Nervousness Pins & Needles in Legs Loss of Memory
- Loss of Taste Fever Tension Numbness in Fingers Ears Ring Diarrhea

Other Symptoms: _____

I UNDERSTAND AND AGREE THAT: Health and accident insurance policies are an agreement between my insurance accompany and me. Smith Chiropractic Office will prepare any necessary forms to assist me in making collections from the insurance company. Any amount authorized will be paid directly to this office and will be credited to my account upon receipt.

CERTIFICATION OF INSURANCE IS NOT A GURANTEE OF PAYMENT FROM THE INSURANCE COMPANY. I AM ULTIMATELY RESPONSIBLE FOR ANY AMOUNT NOT PAID BY THE INSURANCE COMPANY, UNLESS MY INSURANCE STATED OTHERWISE.

All services rendered to me are charged directly to me and I am personally responsible for payment. If I suspend or terminate my care and treatment, any fees for professional services rendered become immediately due and payable revert back to regular standard fees. If my account becomes delinquent and an attorney's assistance or a lawsuit is necessary in collection of my account. I am responsible for any and all fees necessary for collection. I understand a finance charge of 1.5% (18% annually) will be charged on balances after 60 days.

The purpose of Straight Chiropractic Care at this office consists of the detection, location and correction of the Vertebral Sublimation, which produces nerve interference on the brain stem and/or spinal cord nerves. With proper nerve supply restored through the chiropractic adjustment the body can begin the process of repair leading to health. Our only goal is to allow the body to do it's healing and repair it to it's fullest potential. However, if during the course of chiropractic care we encounter unusual Non-Chiropractic findings, I will encourage you (if you desire) to seek advice and diagnosis for those findings from a health care provider who specializes in that area. I accept chiropractic care on this basis alone.

AUTHORIZATION TO PAY DIRECTLY TO PROVIDER: I authorize payment of insurance benefits to be paid directly or by two party checks to the provider listed above. Please make checks payable to Dr. Roger D. Smith

Patient Name: _____ Driver's License #: _____

Guardian or Spouse's Signature Authorizing Care: _____