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 #: ___________________________

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Your Auto Insurance Company: __________________________ Phone Number: _______________________________

Address: ____ Have you reported this to your Insurance: ___________

If applicable Attorney Name/Address & Phone#: ____

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Location of Accident: ____

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

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

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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 ANOUNT 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: ____