NORTON CHIROPRACTIC CENTER

ROBERT MURPHY, D.C.
3725 S. Cleveland-Massillon RD. Norton, OH 44203
Phone 330-825-5502 Fax 330-825-9446

PERSONAL INJURY INSURANCE INFORMATION

Patient Name: _____ DOB:_____

Your Automotive Insurance Information:

Insurance Company: _____

Address: _____

_____

Phone Number: _____ Claim Number:_____

Adjuster Name: _____

Do you have Med-Pay? ___No ___Yes If yes, what is the amount? $_____

Guilty Party Insurance Information:

Insurance Company: _____

Address:_____

_____

Phone Number:_____ Claim Number:_____

Adjuster Name:_____

Attorney Information:

Attorney Name:_____

Attorney Office or Group Name:_____

Address:_____

_____

Phone:_____

NATURE OF ACCIDENT

Date of Accident:___/___/____ Time of Day:_____ Were you: ___Driver ___Passenger ___Back Seat ___Front Seat

Vehicle Year, Make, Model:_____ Other Vehicle:_____

# of people in your vehicle:_____ # of people in other vehicle:_____ Were the police notified? _____Yes - _____No

Were you traveling: ___North ___South ___East ___West Were you struck from: ___Behind ___Front ___Left ___Right

Approx speed of your vehicle:_____MPH

In which direction was the other car traveling: ___North ___South ___East ___West

Approx speed of their vehicle:_____MPH

Were you knocked unconscious? ___Yes ___No If yes, for how long? _____

Where did you go after the accident? ___Home ___Work ____Other ___Hospital- if so, via ___Ambulance or ___On your own

In your own words, please describe the accident:

_____

_____

_____

Did you have any physical complaints before the accident? ___No ___Yes If yes, please describe:

_____

_____

Describe how you felt:

A. **During the accident:**_____
B. **Immediately after the accident:**
   _____
C. **Later that day:**
   _____
D. **The next day:**
   _____

What are your present complaints and symptoms?

_____

_____

Do you have any previous illness(es) that relate to this case? ___No ___Yes If yes, please describe:

_____

_____

Have you ever been involved in an accident, auto or other, before this accident? ___No ___Yes

If yes, please describe and include Date(s), Type(s) of accident(s), and Injury(ies) received:

_____

_____

Have you been treated by another doctor since this accident? ___No ___Yes If yes, please list the doctor's name(s) and address(es):

_____

_____

Since the accident, are your symptoms: ___Improving ___Getting Worse ___Staying the Same

PLEASE CHECK ANY AND ALL SYMPTOMS NOTED AFTER THE ACCIDENT:

	HEADACHE		**DIZZINESS**		**LIGHT BOTHERS EYES**
	NECKPAIN		**HEAVY HEAD**		**LOSS OF MEMORY**
	NECK STIFFNESS		**PINS &NEEDLES IN ARMS**		**EARS RING**
	SLEEPING PROBLEMS		**PINS & NEDDLES IN LEGS**		**FACE FLUSHED**
	BACK PAIN		**NUMBNESS IN FINGERS**		**BUZZING EARS**
	NERVOUSNESS		**NUMBNESS IN TOES**		**LOSS OF BALANCE**
	TENSION		**SHORTNESS OF BREATH**		**FAINTING**
	IRRITABILITY		**FATIGUE**		**LOSS OF SMELL**
	CHEST PAIN		**DEPRESSION**		**LOSS OF TASTE**
	DIARRHEA		**COLD FEET**		**COLD HANDS**
	UPSET STOMACH		**CONSTIPATION**		**COLD SWEATS**

Any symptoms other than those listed above:

_____

Have you lost time from work as a result of this accident? ___No ___Yes If yes, please answer the following:

A. **What is the last date worked?** _____
B. **Type of employment:** _____

C. **Are you being compensated for time lost from work? ___No ___Yes If yes, please state the type of compensation you're receiving:**

_____

Do you notice any activity restrictions as a result of this injury? ___No ____Yes If yes, please describe in detail:

_____

_____

Is there any other information that we should know about this accident? ___No ___Yes If yes, please describe in detail:

_____

_____

RE: MEDICAL REPORTS AND DOCTOR'S LIEN

I do hereby authorize Norton Chiropractic Center to furnish you, my attorney, with a full report of their examination, diagnosis, treatment, prognosis, etc., of myself in regards to the accident in which I was involved.

I hereby authorize and direct you, my attorney, to pay directly to said doctor such sums as may be due and owing him for medical services rendered me both by reason of this accident and by reason of any other bills that are due this office and to withhold such sums from any other settlement, judgment or verdict as may be necessary to adequately protect said doctor. I hereby further give a lien on my case to said doctor against any and all proceeds of my settlement, judgment or verdict which may be paid to you, my attorney, or myself as the result connection therewith.

I fully understand that I am directly and fully responsible to said doctor for all medical bills submitted by him for services rendered me and that this agreement is made solely for said doctor's additional protection and in consideration of his waiting payment. I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee.

Please acknowledge this letter by signing below and returning to the doctor's office. I have been advised that if my attorney does not wish to cooperate in protecting the doctor's interest, the doctor will not await payment, but will require me to make payments on a current basis.

Dated:_____ _____

Signature of Patient

The undersigned, being attorney of record for the above patient, does hereby agree to observe all the terms of the above, and agrees to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect said doctor named above.

Dated: _____ _____

Attorney's Signature

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LEGAL ASSIGNMENT OF BENEFITS

RELEASE OF MEDICAL AND PLAN DOCUMENTS

In considering the amount of medical expenses to be incurred, I, _____,

have insurance and/or employee health care benefits with the above captioned, and hereby assign and convey directly to Norton Chiropractic Center all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer, and my attorney to release to such doctor and clinic any and all documents, insurance policy, and/or claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to above named doctor and clinic to the full extent permissible under the law and under any applicable insurance policies and/or employee health care plan any claim, chose in my action or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above named doctor and clinic to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and clinic in attempts by such doctor and clinic to pursue such claim, chose in action or right against my insurers and/or employee health care plan, including, if necessary, bring suit with such doctor and clinic against such insurers and/or employee health care plan in my name but at such doctor and clinic's expenses.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have fully read and understand this agreement.

_____ _____

Signature of Insured/Guardian Date