HOLLAND CHIROPRACTIC CENTER
A ChiroFlex Company

AUTO ACCIDENT FORM

SSN: _____
Date of Birth: _____ Date: _____
Patient Name: _____
Patient Address: _____

INSURANCE INFORMATION

Auto Insurance Company: _____
Company Address: _____
Policy Number: _____ Claim Number: _____
Do you have any other health insurance coverage? YES _____ NO _____
Health Insurance Company: _____
Insurance Address: _____
Policy Number: _____ Group NUmber: _____
Which of the above is your primary insurance? AUTO _____ HEALTH _____

ACCIDENT INFORMATION

Date of Accident: _____ TIME: _____ POLICE REPORT FILED? YES___ NO___
Location of Accident: _____
Were you stuck from: BEHIND _____ RIGHT SIDE _____ LEFT SIDE _____ FRONT _____
Were you: DRIVER _____ PASSENGER _____
Description of Accident: _____
_____
Were you injured? YES _____ NO _____ Explain any Injuries: _____
_____
Were you unconscious? YES _____ NO _____
Did you have any: FRACTURES_____ CUTS_____ ABRASIONS_____ BRUISES_____
DId you receive treatment at a hospital? YES_____ NO_____
Name of Hospital: _____ Doctor's Name _____
Admitted to hospital? YES_____ NO_____
Indicate what time of treatment you have received: _____
_____
What are you present complaints? _____
_____
Were you off work? YES _____ NO _____ If so, how long? _____
Have you returned to your same job? YES _____ NO _____ IF NOT, WHY? _____
Attorney: Name _____ Address: _____Ph:_____

Patient Signature: _____ Date: _____