Auto Injury Information

Name _____ Today's Date _____

Date of Accident _____ Time of Accident _____ AM PM

Location of Accident _____

Type of Accident: [ ] Auto/Traffic [ ] Work/On Job [ ] At Home [ ] Other _____

Describe how the accident happened in your own words: _____

_____

_____

_____

Name of Hospital: _____ Attended by Dr. _____

Were you x-rayed at the hospital? [ ] Yes [ ] No If so, what was the diagnosis? _____

Were you admitted to the hospital? [ ] Yes [ ] No How long did you stay? _____

What treatment was rendered?

_____

List any other doctors you have seen as a result of this accident:

_____

Have you lost any time from work because of this accident? [ ] Yes [ ] No

If yes, give days of disability: _____

Totally disabled from _____ to _____ Partially disabled from _____ to _____

Have you returned to work since the accident? [ ] Yes [ ] No Were you wearing a seat belt? [ ] Yes [ ] No

What kind of vehicle hit yours? _____ What kind of vehicle were you in? _____

If auto accident, were you the [ ] Driver [ ] Passenger [ ] Pedestrian?

If passenger, were you sitting in the [ ] Front [ ] Right Rear [ ] Left Rear? [ ] Other ?_____

Did your vehicle hit other vehicle(s)? [ ] Yes [ ] No Estimated speed of your vehicle at impact? _____ MPH

Was your vehicle hit by another vehicle(s)? [ ] Yes [ ] No Estimated speed of other vehicle at impact? _____ MPH

Did your car strike the other(s) involved? [ ] Yes [ ] No or did the other car strike yours? [ ] Yes [ ] No [ ] undetermined

VEHICLE YOU WERE IN:

Driver _____

Insured: _____

Address: _____

Phone: _____

Auto Insurance Co.: _____

Ins. Co. Address: _____

Adjuster: _____

Phone: _____

Policy #: _____

Claim # _____

OTHER VEHICLE

Driver: _____

Insured: _____

Address: _____

Phone:_____

Auto Insurance Co.: _____

Ins. Co. Address: _____

Adjuster: _____

Phone: _____

Policy #: _____

Claim # _____

Did you require post-accident hospitalization? [ ] Yes [ ] No

Auto Injury Information

CHECK THE 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 too heavy	[ ] Depression	[ ] Fainting spells	[ ] Constipation
[ ] Back pain	[ ] Pins & needles in Arms	[ ] Light bothers eyes	[ ] Loss of smell	[ ] Cold sweats
[ ] Nervousness	[ ] Pins & needles in Legs	[ ] Loss of memory	[ ] Loss of taste	[ ] Fever
[ ] Tension	[ ] Numbness in fingers	[ ] Ears ring	[ ] Diarrhea	[ ] _____

Symptoms other than above: _____

Have you lost days of work? [ ] YES [ ] NO Dates: _____

Name of your Insurance Company involved: _____

Name of person at your Insurance Company responsible for injuries: _____

Have you been contacted by an Insurance Adjuster or Company Representative regarding this claim? [ ] YES [ ] NO

Do you have an attorney who has advised you in this case? [ ] YES [ ] NO

Name: _____

Address of Attorney: _____

Phone No: _____

Patient's Signature: _____ Date: _____

BAY CITY
CHIROPRACTIC CENTER
SEE US FIRST FOR RELIEF THAT LASTS

ASSIGNMENT AND INSTRUCTIONS FOR DIRECT PAYMENT TO DOCTOR
PRIVATE AND GROUP HEALTH INSURANCE AND ACCIDENT INSURANCE

To: _____
_____
_____

David O. Krenek, D.C. (herein called Bay City Chiropractic Center) owns and assignment of cause of action to the extent of all medical expenses incurred from the referenced patient through Dr. Krenek who has a claim against your insured, _____. Your insured or Claimant, as appropriate, hereby instructs and directs the _____Insurance Company t direct all correspondence directly to the chiropractor and make all checks payable and mailed directly to: Bay City Chiropractic Center, 1401 Avenue G, Bay City, TX 77414. If insured's current policy prohibits direct payment to the doctor for chiropractic care and treatment, then you are instructed to make out the check to Bay City Chiropractic Center.

Claimant grants limited power of attorney to Bay City Chiropractic Center to sign his or her name to the back of any insurance draft made out to Bay City Chiropractic Center and Claimant or to the Claimant individually for payment of services rendered by that office, not to exceed the amount of those fees due.

A photocopy of this Assignment shall be considered as effective and valid as the original.

Claimant also authorizes the chiropractor to release any information pertinent to Claimant's case to any insurance company, adjuster, or attorney involved in this case or claim without any liability to the Chiropractor.

_____
Signature of Policyholder
(Claimant/Patient)

_____
Signature of Claimant/Patient if
other than policyholder

_____
Date

1401 AVENUE G, BAY CITY, TEXAS 77414 • (979) 245-6844

Dr. David O. Krenek, D.C.
Member: American Chiropractic Association, Texas Chiropractic Association • Certified: Low Back Safety Instructor, Impairment Rating • Adjunct Professor: Texas Chiropractic College • Lecturer

Soothing relief for your:
- Low back and neck pain
- Personal injuries
- Work-related injuries
- Carpal tunnel syndrome
- Herniated discs
- Extremity pain
- TMJ
- Headaches

For your convenience:
- Evening and same-day appointments
- Easy payment plans
- Walk-ins welcome
- 24-hour emergency care
- Insurance accepted and filed
- Visa and MasterCard accepte