ACCIDENT INSURANCE INFORMATION

Name: _____

Date of Accident: _____

State of Accident: _____

Claim Number: _____

Name of Insurance Company to be billed:

_____

Billing address for Claims: _____

_____

_____

Name of Claim Representative:

_____

Phone # of Claim Rep.: _____

PATIENT CONDITION

Were you unconscious immediately after the accident? ___ No ___Yes If yes, for how long?_____

Please describe how you felt immediately after the accident? _____

_____

_____

TREATMENT

Did you go to the hospital? ___Yes ___No

When did you go? ___ Immediately after accident ___ Next Day ___2 days or more after the accident

How did you get to the hospital? ___ Ambulance ___ Private

Name of hospital:_____ Name of Doctor:_____

Diagnosis:_____

_____

Treatment received_____

Xrays taken: Yes __ No __ If so, where? _____

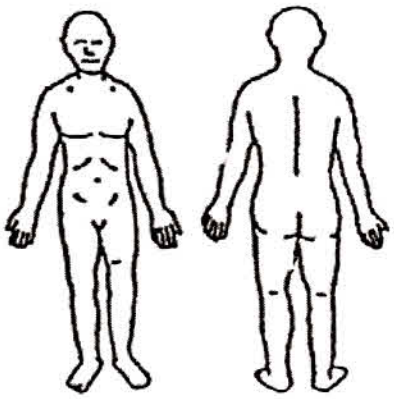
SYMPTOMS/INJURIES

Have you been able to work since this injury? ___Yes ___No How many work days have you missed?_____

Prior to the injury were you able to work on an equal basis with others your age? ___ Yes ___ No

If you have had any of the following symptoms since your injury, please indicate:

__ Arm/shoulder pain	__ Feet/toe numbness	__ Neck pain
__ Back pain	__ Hand/finger numbness	__ Neck stiff
__ Back stiffness	__ Headaches	__ Shortness of breath
__ Chest pain	__ Irritability	__ Sleep difficulty
__ Dizziness	__ Jaw problems	__ Stomach upset
__ Ear buzzing	__ Leg pain	__ Vision blurred
__ Ear ringing	__ Memory Loss	__ Tension
__ Fatigue	__ Nausea	



Is the condition getting progressively worse? ___ Yes ___ No ___ Unknown

Mark an X on the diagram where you continue to have pain, numbness, or tingling:

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain): _____

Type of pain:	__ Sharp	__ Dull	__ Throbbing	__ Numbness
	__ Aching	__ Shooting	__ Burning	__ Tingling
	__ Cramps	__ Stiffness	__ Swelling	__ Other_____

How often do you have this pain? _____ Is it constant, or does it come and go?_____

Does it interfere with your: ___ Work ___ Sleep ___ Daily routine ___ Recreation?

Activities or movements that are painful to perform: __ Sitting __ Standing __ Walking __ Bending __ Lying down

I certify that the above information is correct to the best of my knowledge. I authorize benefits to be paid to the doctor, and the release of my medical records required by the Insurance Co. or lawyers to expedite payment of claims submitted. I understand that I am financially responsible for any services not covered by the Ins. Co., and agree to pay any outstanding balance in a timely manner.

Patient signature:_____ Date:_____

Joseph L. Dumovic, D.C., N.D. 3480 S. 152nd, Tukwila, WA 98188 Ph: 206-244-5216 Fax: 206-244-0897

VEHICLE ACCIDENT INFORMATION

Joseph L. Dumovic, D.C., N.D. 3480 S. 152nd, Tukwila, WA 98188 Ph: 206-244-5216 Fax: 206-244-0897

PATIENT INFORMATION

Date _____

Patient Name _____

Date of Accident _____ **Time of Accident** _____

Please describe the accident in your own words _____

_____

_____

_____

Were you the: ☐ Driver ☐ Front Passenger ☐ Pedestrian ☐ Rear Passenger

How many people were in the accident vehicle? _____

ACCIDENT SITE

Road/Street Name: _____

City/State: _____

Nearest intersection with Rd/St: _____

Driving Conditions: __Dry, __ Wet, __ Icy, _____ Other

Which direction were you headed? _____

Speed you were travelling: _____

VEHICLE

Make and model of vehicle you were in:

_____

Were you wearing a seat belt? __ Yes __ No

If yes, what type? __ Lap __ Shoulder

Was the vehicle equipped with airbags? __ Yes __ No

If yes, did they initiate properly? __ Yes __ No

Did you have a head rest? __ Yes __ No

If yes, what was the position of the headrest?

__ Low __ Mid-position __ High

IMPACT

Did your car impact another vehicle: __ Yes __ No

Did your car impact a structure: __ Yes __ No

If yes, explain _____

_____

Did any part of your body strike anything in the vehicle?

___ Yes ___ No If yes, explain _____

Was impact from:

__ Front __ Rear __ Left __ Right __ Other_____

At the time of impact were you:

__ Looking to the left __ Looking to the right

__ Looking up __ Looking down

__ Looking straight ahead

Were you: ___ Surprised by impact ___ Braced for impact

Were both hands on the wheel? __ Yes __ No

If no, which hand was on the wheel? __ Left __ Right

Was your foot on the brake? __ Yes __ No

If yes, which foot was on the brake? __ Left __ Right

OTHER VEHICLE

(If applicable)

Make and model of other vehicle: _____

Which direction was the other vehicle headed? _____

Speed other vehicle was travelling? _____

POLICE

Did the police come to the accident site? __ Yes __ No

Were there any witness? __ Yes __ No

Was a police report filed? __ Yes __ No

Was a traffic violation issued? __ Yes __ No

If yes, to whom? _____

Joseph L. Dumovic, D.C., N.D., Inc., P.S.

Mailing: PO BOX 177
Hobart, WA 98025
Phone (206)244-5216 - Fax: (206) 244-0897

DOCTOR LETTER OF PROTECTION

To Attorney: _____

Address: _____

Patient Name: _____

I hereby authorize and direct my attorney, as listed above, to pay directly to Dr. Joseph L Dumovic for any professional services rendered to me by reason of this accident. I further give a lien on my case to Dr. Joseph L. Dumovic against any and all proceeds to any settlement, judgments, or verdict, which may be paid to my attorney, listed above or myself as the result of the injuries for which I have been treated. Please note that, due to the fact that these cases often take an extended amount of time to settle they do not qualify for any discounted arrangements.

Prior to disbursing any settlement or recovery, the attorney's office listed above, will verify the amount of any outstanding fees. Also, this office will protect your bill for services rendered to our client out of any judgment or settlement received in this case.

As the patient I fully understand that I am directly and fully responsible to Dr. Joseph L. Dumovic for all medical bills submitted by him for services rendered to me and that this agreement is made solely for additional protection and consideration of his awaiting payment.

Patient Signature: _____ Date: _____

Attorney Signature: _____ Date:_____