AUTO ACCIDENT QUESTIONNAIRE

Patient Name: ___________________________________ Current Date: ___________________________

Date of Accident: ______________ Time: ________ Weather Conditions: _____________________

Location of Accident: ____

Were you a: ( ) driver ( ) passenger ( ) pedestrian Were you wearing a seatbelt? ( ) yes ( ) no

Were you struck: ( ) from behind ( ) right side ( ) left side ( ) front ( ) parked

Did your car strike another? ( ) yes ( ) no Did another car strike you? ( ) yes ( ) no

Did the police come to the scene? ( ) yes ( ) no Accident report #: _______________________

As a result of the accident, were you issued any citations? ( ) yes ( ) no

Please describe the accident: ____

____

Did you lose consciousness? ( ) yes ( ) no Did you require hospitalization? ( ) yes ( ) no

Were you wearing a seatbelt? ( ) yes ( ) no Did your airbags deploy? ( ) yes ( ) no

Did you visit an emergency room? ( ) yes ( ) no Were you taken by ambulance? ( ) yes ( ) no

Have you seen any other practitioners for treatment from this accident? ( ) yes ( ) no

If so, please list names and dates: ____

Have you lost days of work? ( ) yes ( ) no Are your symptoms: ( ) improving ( ) worse ( ) same

Attorney Information

Attorney Name: _________________________________ Attorney Phone: ( ) ____________________

Address: ____

Attorney Fax: ( ) _____________________________

91A. North State Street | Concord, NH | 03301
phone: (603) 724-2297 | fax: (603) 369-3017
www.performancehealthnh.com

Auto Insurance Information (REQUIRED)

*Do you have medical payment coverage through your auto insurance? ( ) yes ( ) no

Auto Insurance Company: ____

Auto Policy #: ____

Name of Insured:______________________ Date of Birth: ______________________

Address: ____

Phone: ( ) ______________________ Adjuster Name: ______________________

Accident Claim #: ______________________ Adjuster Phone: ( ) ______________________

*Was the claim filed through another driver's auto insurance? ( ) yes ( ) no

Other Auto Insurance Company: ____

Other Auto Policy #: ____

Name of Insured:______________________ Phone: ( ) ______________________

Address: ____

Adjuster Name: ______________________

Accident Claim #: ______________________ Adjuster Phone: ( ) ______________________

Primary Health Insurance Information (REQUIRED)

Insurance Company: ______________________ Member ID#: ______________________

Subscriber Name: ______________________ Date of Birth: ______________________

Phone: ( ) ______________________ Relationship to Patient: ______________________

Address: ____

TIME OF SERVICE DISCOUNT FOR CASH PATIENTS

In lieu of submitting to primary medical insurance, I elect to pay for services at the time they are rendered for a discount of ten percent (10%) of the full rate, which will be applied to the total charges for that service date. Payment will be made in the form of cash, or credit/debit card and are due at the time of service. Additionally, I understand and acknowledge that reimbursement for this payment from insurance proceeds is my sole responsibility.

Dated the _______ day of _____________, 20____.

Patient's Name: ____

Patient's Signature: ____

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