PERSONAL INJURY QUESTIONNAIRE

INFORMATION ABOUT YOU

Name:_____ Birthday:_____

Address:_____

City:_____ State:_____ Zip Code:_____

Home Phone:_____ Cellular Phone:_____

Sex: ( ) Male or ( ) Female

INSURANCE INFORAMTION

Your Insurance Company:_____ Policy #:_____

Name on Policy (If other than self):_____

Contact name:_____ Telephone:_____

Responsible Party's Name:_____

Claim #:_____

Comments:_____

_____

INFORMATION ABOUT YOUR ATTORNEY (if applicable)

Name:_____ Telephone:_____

INFORMATION ABOUT YOUR ACCIDENT

Date of Accident:_____ Time of Day:_____

Were You: ( ) Driver ( ) Passenger ( ) Front Seat ( ) Back Seat

Number of people in you vehicle?_____ Were you wearing your seat belt?_____

What direction were you headed? ( ) North ( ) South ( ) East ( ) West

What direction was the other vehicle headed? ( ) North ( ) South ( ) East ( ) West

Were you stuck from: ( ) Behind ( ) Front ( ) Left side ( ) Right side

Approximate speed of your car_____mph. Approximate speed of other car_____mph.

Were you knocked unconscious?_____

Were police notified?_____ (If yes please be sure we have a copy of the accident report)

In your own word, describe the accident:_____

_____

_____

Did you have any physical complaints BEFORE the accident? ( ) Yes or ( ) No If yes, Please describe:_____

_____

Please describe how you felt:

DURING the accident:_____

IMMEDIATELY AFTER THE ACCIDENT:_____

_____

LATER THAT DAY:_____

THE NEXT DAY:_____

What are your PRESENT complaints and symptoms?_____

_____

_____

Do you have any congenital (from birth) factor which relate to this problem?_____

_____

Do you have any previous illnesses/injury's, which relate to this case? ( ) Yes or ( ) No

If yes, please describe:_____

_____

Have you ever been involved in an accident before? ( ) Yes or ( ) No

If yes, please describe, including date(s) and type(s) of accidents as well as injuries received:_____

_____

Where were you taken after your current accident?_____

Have you been treated by another doctor since the accident? ( ) Yes or ( ) No If yes, names:_____

Since this injury occurred, are your symptoms ( ) improving ( ) getting worse ( ) same

Check symptoms you have noticed since the accident:

__ Headache	__Irritability	__Numbness-Toes	__ Face Flushed	__Feet Cold
__ Neck Pain	__Chest Pain	__ Shortness-Breath	__ Buzzing in Ears	__ Hands Cold
__ Neck Stiff	__ Dizziness	__ Fatigue	__ Loss of Balance	__ Stomach-upset
__ Sleeping Problem	__ Head is Heavy	__Depression	__Fainting	__ Constipation
__ Back Pain	__ Pins/Needles Arms	__Light Sensitive Eyes	__ Loss of Smell	__ Cold Sweats
__ Nervousness	__ Pins/Needles Legs	__ Loss of Memory	__ Loss of Taste	__ Fever
__ Tension	__ Numbness-Finger	__ Ears Ring	__ Diarrhea	

Symptoms other than above:_____

_____

Have you lost time from work as a result of this accident? ( ) Yes or ( ) No

Do you notice any activity restrictions as a result of this injury? ( ) Yes or ( ) No

If yes, please describe:_____

_____

Other pertinent information:_____

_____

_____

I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I authorize release of any information necessary to process my insurance claims and assign and request payment directly to my physicians. The above information is true and accurate to the best of my knowledge.

_____ _____

Patient or Guardian Signature Date

Doctors Lien

IRREVOCABLE ASSIGNMENT, SECURITY AGREEMENT AND AUTHORIZATION INSURANCE BENEFITS AND ATTORNEY

I hereby authorize and direct you, (insurance company, and/or attorney), to pay directly to Ryan C. Brinka, D.C. dba Brinka Family Chiropractic (the "Provider") such sums as may be due and owing the Provider for health care services rendered me by reason of accident or illness. Further, I authorize and direct you to withhold such sums from any disability benefits, medical benefits, no-fault benefits, health and accident benefits, Workers' Compensation benefits, or any other insurance benefits obligated to be paid to me or from any settlement or judgment on my behalf as may be necessary to adequately protect the financial interests of the Provider.

I hereby grant the provider a security interest in any and all insurance benefits, and any and all proceeds of any settlement or judgment which may be payable to me as a result of the injuries or illness for which I have been treated by the Provider.

In the event my insurance company becomes obligated to make payment to me for services rendered by the Provider and refuses to make such payments upon demand by the Provider or me, I hereby assign and transfer to the Provider any and all causes of action that I may have against such insurance company, and authorize the Provider to prosecute said cause of action either in my name or in Provider's name. Further, I authorize the Provider to compromise, settle or otherwise resolve such claim or cause of action in such manner as the Provider shall determine in his sole discretion.

I understand that I remain personally responsible for the payment of all amounts due the Provider for health care services. I further understand and agree that this Assignment, Security Agreement and Authorization do not constitute consideration for the Provider to defer collection efforts for payment to health care services and the Provider may, at his option, demand immediate payment from me upon rendering such services.

I hereby authorize the Provider to release any information pertinent to my case to any insurance company, adjuster, or attorney to facilitate collection of insurance benefits or the proceeds of any settlement or judgment under this Assignment, Security Agreement and Authorization.

I hereby appoint the Provider as my attorney-in-fact and agent to endorse/sign my name on any and all checks issued by the insurance company to me as payment of any accounts due and payable to the Provider for health care services.

I agree to pay the Provider for all costs of collection efforts, including court costs and attorneys fees, if the Provider must take any action to collect an outstanding balance on my account.

Dated:_____ Patient Signature:_____

KNOW ALL MEN BY THESE PRESENTS: That I, _____ authorize any doctor, hospital, employer, or other person, to who a signed original or photocopy of this authorization is delivered, to furnish any information, copies of records, reports, and/or X-rays which may be requested.

Patient's Signature:_____