Leading Edge Medical

Accident Questionnaire

Name: ______________________________________ Age: _________Date of birth: ____________ Date: __________
LAST FIRST MIDDLE

Address: ____________________________________City, State, Zip: _______________________________

Current Symptoms:____

____

Please list any recent x-rays, lab or other tests: **Date** **Facility/Doctor**

____

____

Date of Crash: _______________________________ Hour: _____________AM __________PM ________________

Specific Location of Crash: ____

Describe in detail, in your own words, how the crash/accident happened: _______________________________

____

____

____

AUTOMOBILE/MOTORCYLCE ONLY

In the crash: Were you the ☐ Driver ☐ Passenger ☐ Pedestrian ☐ Other?
____

Did your vehicle strike the other vehicle? ☐Yes ☐No Did the other vehicle strike your car? ☐Yes ☐No

Were you struck from? ☐ Behind ☐ Front ☐ Driver Side ☐ Passenger Side **Motorcycle Only**: ☐Left Side ☐ Right Side

Were traffic citations issued to? ☐ You ☐ Driver of Your Vehicle ☐ Driver of the Other Vehicle ☐ No Citations Given

Was your vehicle heading? ☐ North ☐ South ☐ East ☐ West on ____________________________ (Street/Highway)

Was the other heading? ☐ North ☐ South ☐ East ☐ West on ________________________________ (Street/Highway)

CHECK ANY OF THE FOLLOWING SYMPTOMS YOU HAVE NOTICED SINCE THE CRASH/ACCIDENT:

☐ Headache	☐ Middle Back Pain	☐ Lower Back Pain	☐ *Ears Ring*
☐ Neck Pain	☐ Chest Pain	☐ Lower Back Stiffness	☐ *Buzzing in Ears*
☐ Neck Stiffness	☐ Bruised Chest	☐ Radiating Pain	☐ *Dizziness*
☐ Sleeping Problems	☐ Bruising Anywhere	☐ Tingling in Legs	☐ Loss of Smell
☐ *Depression*	☐ *Blurred Vision*	☐ Tingling in Arms	☐ Loss of Taste
☐ *Anxiety*	☐ Sensitivity to Light	☐ Jaw Pain	☐ *Any Burns*
☐ *Fainting*	☐ Upper Arm Pain	☐ Upper Leg Pain	☐ *Any Stitches*
☐ Muscle Spasms	☐ Lower Arm Pain	☐ Lower Leg Pain	☐ *Any Cuts*

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☐ Other Symptoms: ____

Have you lost time from work? ☐ Yes ☐ No: If Yes, Dates: __________________ to ____________________

Where did you go after the crash? ☐ Hospital ☐ Urgent Care ☐ Home ☐ Work ☐ Other ____________________

Were you taken by ambulance? ☐ Yes ☐ No **To which hospital?** ______________________________

Address: ______________________________ Date of Hospitalization: ____________________

Attending E.R. Doctor: ____________________ Treatment Given? ____________________

Have you done any of the following since the crash:

☐ Ice ☐ Medication (name)_______ ☐ Rest

☐ Heat (any kind) ☐ Exercise ☐ Other________________

PLEASE PROVIDE US WITH THE APPROPRIATE INSURANCE INFORMATION:

1) YOUR AUTOMOBILE INSURANCE CARRIER: ______________________________

Address: ____________________Telephone: (_____) ____________Insured: ______________

Claim #: ____________________Policy #: ____________________

Claim Representative: ____________________

Telephone: (______) ____________________ Fax: (_______) ____________________

Med-Pay Benefits: ____________ Uninsured (UM) Benefits: ___________ Underinsured (UIM) Benefits: __________

Have you signed a selection waiver of benefits? ☐ Yes ☐ No ☐ Unsure

Are you a full time Student? ☐ Yes ☐ No Do you reside with a relative? ☐ Yes ☐ No

2) YOUR HEALTH INSURANCE COMPANY: ______________________________

Address: ____________________ Insured: ____________________

Date of Birth: ____________________Policy #: ____________________ SS#: ______________

Telephone: (______) ____________________ Fax: (_______) ____________________

3) ADVERSE OR THIRD PARTY AUTOMOBILE INSURANCE CARRIER: ____________________

Address: ____________________ Claims Rep: ____________________

Claim #: ____________________Policy #: ____________________Insured: ______________

Telephone: (______) ____________________ Fax: (_______) ____________________

4) ATTORNEY: ____________________Legal Assistant: ____________________

Address: ____

Telephone: (______) ____________________ Fax: (_______) ____________________

HIPAA Compliance

Our office is required by law to maintain the HIPAA Notice of Privacy Practices. This notice explains our legal duties and privacy practices with respect to your protected health information. Signature below acknowledges that I have read this Notice of our Privacy Practices. A copy will be provided to me upon request.

Patient Signature: ____________________ Date:____________________

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