

# MODERN FAMILY CHIROPRACTIC

"The Modern Approach to Family Wellness"  
www.ModernFamilyChiropractic.com



Dr. Daniel Bentz, D.C.  
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**(508) 543-1866**

OFFICE HOURS:  
Mon, Tues Wed 9-7  
Thurs 12-7, Fri 9-3  
Other times by appointment  
FAX (508) 543-1867

## Motor Vehicle Accident Report

Claim # \_\_\_\_\_ Patient ID# \_\_\_\_\_

### PATIENT INFORMATION

Date \_\_\_\_\_

Patient Name \_\_\_\_\_

Date of Accident \_\_\_\_\_ Time of Accident \_\_\_\_\_  a.m.  
 p.m.

Please describe the accident in your own words: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Were you the:  Driver  Front Passenger  Rear Passenger  Pedestrian

How many people were in the accident vehicle? \_\_\_\_\_

### ACCIDENT SITE

Road/Street Name \_\_\_\_\_

City/State \_\_\_\_\_

Nearest intersection with road/street \_\_\_\_\_

Driving conditions  Dry  Wet  Icy  Other \_\_\_\_\_

Which direction were you headed? \_\_\_\_\_

Speed you were traveling? \_\_\_\_\_

### VEHICLE

Make and model of vehicle you were in: \_\_\_\_\_

Were you wearing a seatbelt?  Yes  No  
If yes, what type?  Lap  Shoulder

Was vehicle equipped with airbags?  Yes  No  
If yes, did it/they inflate properly?  Yes  No

Did your seat have a headrest?  Yes  No  
If yes, what was the position of the headrest?  
 Low  Midposition  High

### OTHER VEHICLE

(if applicable)

Make and model of other vehicle \_\_\_\_\_

Which direction was other vehicle headed? \_\_\_\_\_

Speed other vehicle was traveling \_\_\_\_\_

### 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 straight ahead  Looking to the right  
 Looking to the left  Looking down  
 Looking up

Were both hands on the steering wheel?  Yes  No  
If no, which hand was on the wheel?  Right  Left

Was your foot on the brake?  Yes  No  
If yes, which foot was on the brake?  Right  Left

Were you:  Surprised by impact  Braced for impact

### POLICE

Did the police come to the accident site?  Yes  No

Were there any witnesses?  Yes  No

Was a police report filed?  Yes  No

Was a traffic violation issued?  Yes  No  
If yes, to whom? \_\_\_\_\_

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## PATIENT CONDITION

Were you unconscious immediately after the accident?  Yes  No 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 transportation

Name of hospital \_\_\_\_\_ Name of doctor \_\_\_\_\_

Diagnosis \_\_\_\_\_

Treatment received \_\_\_\_\_

X-rays taken \_\_\_\_\_

## 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  check:

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Arm/shoulder pain | <input type="checkbox"/> Feet/toe numbness    | <input type="checkbox"/> Neck pain           |
| <input type="checkbox"/> Back pain         | <input type="checkbox"/> Hand/finger numbness | <input type="checkbox"/> Neck stiff          |
| <input type="checkbox"/> Back stiffness    | <input type="checkbox"/> Headaches            | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Chest pain        | <input type="checkbox"/> Irritability         | <input type="checkbox"/> Sleep difficulty    |
| <input type="checkbox"/> Dizziness         | <input type="checkbox"/> Jaw problems         | <input type="checkbox"/> Stomach upset       |
| <input type="checkbox"/> Ear buzzing       | <input type="checkbox"/> Leg pain             | <input type="checkbox"/> Tension             |
| <input type="checkbox"/> Ear ringing       | <input type="checkbox"/> Memory loss          | <input type="checkbox"/> Vision blurred      |
| <input type="checkbox"/> Fatigue           | <input type="checkbox"/> Nausea               |  |

Is this condition getting progressively worse?  Yes  No  Unknown

Mark an X on the picture 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) \_\_\_\_\_

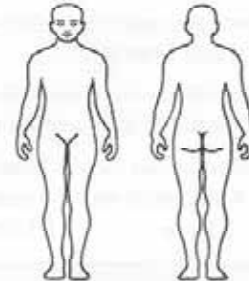
- Type of pain:  Sharp  Dull  Throbbing  Numbness  
 Aching  Stinging  Burning  Tingling  
 Cramps  Stiffness  Swelling  Other \_\_\_\_\_

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.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

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## Automobile Insurance Information for Filing of Health Claims

Patient Name \_\_\_\_\_  
Today's Date \_\_\_\_\_  
Date of Accident \_\_\_\_\_

**CLAIM #** \_\_\_\_\_ (This is assigned when you register a claim with your auto insurance. Your carrier should determine who claims should be filed to.)

### **FILE CLAIMS TO:**

Insurance Company: \_\_\_\_\_  
Phone # \_\_\_\_\_  
Fax# \_\_\_\_\_  
Claims Contact Person: \_\_\_\_\_  
Address to Mail Claims: \_\_\_\_\_  
\_\_\_\_\_

**Is an Attorney Handling Your Case?** [ No ] [ Yes ] If yes, complete below.

Attorney Name: \_\_\_\_\_  
Firm Name: \_\_\_\_\_  
Phone # \_\_\_\_\_  
Fax# \_\_\_\_\_  
Claims Contact Person: \_\_\_\_\_  
Address to Mail Claims: \_\_\_\_\_  
\_\_\_\_\_

### **Personal Health Insurance** (In case you or the other party has insufficient health coverage for you)

Insurance Company \_\_\_\_\_  
Policy/ Group # \_\_\_\_\_  
Member Services Phone # \_\_\_\_\_

Notes: In most automobile accidents, our office encourages you to have an attorney to help you manage your automotive and personal claims for the duration of your care. As auto insurance becomes more complicated to file, you may consider attorney counsel at any time. This will allow you to focus on your recovery and return to pre-accident status. If you choose not to utilize an attorney, we will file your health claims to the proper insurance agency for reimbursement. Some automotive insurance plans have limits of coverage that would require the use of your personal health insurance for extended chiropractic benefits. Though most services are covered by personal injury coverage, any uncovered health expenses will be charged at the settlement period.  
Thank You.