Judith Boothby MS DC PC
1620 SE Ankeny St
Portland OR 97214
(P & F) 503-233-0943

AUTO ACCIDENT DETAILS FORM

Today's Date:	Injury Date:	Time of Accident: AM/PM
Patient Name:		DOB:
Location of Accident:		
Describe accident in detail, including speed of vehicles:		
Were police called to the scene: Y N	Were citations issued: Y N	
Name of driver of vehicle in which you were riding:		
Were you: Driver Passenger Pedestrian Cyclist		
Road conditions: Ice Wet Rain Dark Other:		
Were you struck from: Behind Front Left Right		
Were you aware that the accident was about to occur: Y N		
Were seat/shoulder harnesses properly fastened: Y N		
Were you braking: Y N	Were you bracing for impact: Y N	Did your airbag deploy: Y N
What was your head position prior to impact:		
What was your body position prior to impact:		
Which part of the car did your head hit:		
Were you unconscious: Y N	In shock: Y N	Dazed: : Y N
Were you hospitalized: Y N	Name of hospital:	
What were your symptoms immediately following the accident:		
Has the accident resulted in disability: : Y N		Work loss: Y N
Date that disability began: / /	Still disabled: Y N	On medication: Y N
Check symptoms you have noticed since the accident:		
☐ Arm "falls asleep"	☐ Face flushed	☐ Memory loss
☐ Back pain	☐ Loss of smell	☐ Neck pain
☐ Buzzing in ears	☐ Fainting	☐ Nervousness
☐ Chest pain	☐ Fatigue	☐ Numbness in fingers
☐ Cold hands	☐ Feet feel cold	☐ Numbness in foot/toes
☐ Constipation	☐ Headache	☐ Poor sleep
☐ Depression	☐ "Heavy head"	☐ Shortness of breath
☐ Diarrhea	☐ Irritability	☐ Stiff neck
☐ Dizziness	☐ Legs/feet fall asleep	☐ Stomach upset
☐ Ears ringing	☐ Loss of balance	☐ Tension
☐ Eyes sensitive to light	☐ Loss of taste	☐ Shooting pain in arms
☐ Shooting pain in legs	☐ Other	☐
Other, related symptoms:		
Have you seen another doctor for this accident: Y N		
Name of other doctor:		
Treatment you received:		
Response to treatment:		

Thank You

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AUTO ACCIDENT INSURANCE INFORMATION

Today's Date:	Injury Date:	Accident: Wrk Related NonWrk Related
Patient Name:		
Address:		
City:	State:	Zip:
H Phone:	Cell:	SS#:
Sex: M F	Relationship: S M D W P	DOB:
Employer:		
Address:		
Phone:	Work StatuS: FT PT Retired Student	

Adult Responsible for Minor

You are: Parent Other	Please explain other:

Responsible person please complete following section:		
Name:		
Address:		
City:	State:	Zip:
H Phone:	Cell:	SS#
Sex: M F	Relationship: S M D W P	Birthday:
Employer:		
Address:		
Phone:	Work StatuS: FT PT Retired Student	

Patient's Insurance Company

Name:		Open claim verified: Y N
Address:		
City:	State:	Zip:
Phone:	Contact Person:	
ID/Claim #:		If BC, P Code:
Policy #:	Group Name:	Group #:
Policy Holder Name:		
Address:		
City:	State:	Zip:
H Phone:	Cell:	SS#:
Sex: M F	Relationship: S M D W P	Birthday:
Employer:		
Address:		
Phone:	Work StatuS: FT PT Retired Student	

Medical Release of Information Authorization

I hereby authorize the release of any medical information necessary to process this claim:

Signed: Date:

Payment Authorization

Choose one:

- ☐ Bill my insurance. I authorize payment of medial benefits to the physician or supplier for services rendered. I agree to pay deductibles and co-payment at time of service. I will be responsible to the doctor for payment of any part of my bill not covered by insurance.
- ☐ I will pay at time of service. I do not authorize insurance billing. I am responsible for payment.

Signed: Date: