

**Bartz Chiropractic**  
**814 Pine Island Road, Suite 306**  
**Cape Coral, FL 33991**

**Auto Accident History**

**Date** \_\_\_\_\_

**Name** \_\_\_\_\_  
          **First**                  **Middle**          **Last**

**Address** \_\_\_\_\_

**City** \_\_\_\_\_ **State** \_\_\_\_\_ **Zip** \_\_\_\_\_

**Soc Sec #** \_\_\_\_\_ **Home Phone** \_\_\_\_\_

**Birthdate** \_\_\_\_\_ **Age** \_\_\_\_\_ **Gender: M F**

**Marital Status: M S W D**      **Number of Children** \_\_\_\_\_

ATTORNEY INFORMATION	
<b>Name</b> _____	_____
<b>Address</b> _____	_____
_____	_____
<b>Work Phone</b> _____	_____

**AUTO ACCIDENT INFORMATION**

**Date of Accident:** \_\_\_\_\_ **Time of Accident:** \_\_\_\_\_

In your own words, please describe how accident happened: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

In your own words, please describe injury received and to what parts of body: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What type of car were you in? \_\_\_\_\_

What type of car was other driver in? \_\_\_\_\_

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

Where you wearing your seatbelt?    ( ) Yes    ( ) No

Does your car have airbags?    ( ) Yes    ( ) No      If yes, did they inflate?    ( ) Yes    ( ) No

Approximate speed of vehicle at time of accident: \_\_\_\_\_

Number of people in your vehicle? \_\_\_\_\_ Other Vehicle? \_\_\_\_\_

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

What direction were you headed?    ( ) North    ( ) East    ( ) South    ( ) West  
on (name of street) \_\_\_\_\_

What direction was the other vehicle headed? ( ) North ( ) East ( ) South ( ) West  
on (name of street) \_\_\_\_\_

Were you knocked unconscious? ( ) Yes ( ) No. If yes, for how long? \_\_\_\_\_

Did any part of your body strike anything in vehicle? ( ) Yes ( ) No

If yes, please describe: \_\_\_\_\_  
\_\_\_\_\_

Was there damage to your car? ( ) Minor ( ) Moderate ( ) Extensive ( ) Totaled

Was the accident? ( ) Complete Surprise ( ) Saw car coming (able to brace body for impact)

Position of body at impact: ( ) Straight Ahead ( ) Slouched ( ) Rotated Left ( ) Rotated Right

Were police notified? ( ) Yes ( ) No

Was a police report filed? ( ) Yes ( ) No

Was a traffic violation issued ( ) Yes ( ) No If so, to whom? \_\_\_\_\_

Please describe how you felt:

a. DURING the accident: \_\_\_\_\_

b. IMMEDIATELY AFTER the accident: \_\_\_\_\_

c. LATER THAT DAY \_\_\_\_\_

d. THE NEXT DAY: \_\_\_\_\_

Where were you taken after the accident? \_\_\_\_\_

How long after the accident did you go? \_\_\_\_\_

Have you ever been treated by a hospital or another doctor since the accident? ( ) Yes ( ) No.

If yes, please list doctor's name and address: \_\_\_\_\_

What type of treatment did you receive? \_\_\_\_\_

What recommendations were made? \_\_\_\_\_

Since this injury occurred, are your symptoms: ( ) Improving ( ) Getting Worse ( ) Same

Home care how you treat symptoms: \_\_\_\_\_

**CHECK SYMPTOMS YOU HAVE NOTICED SINCE ACCIDENT:**

- |                                      |  |   |  |   |  |
|--------------------------------------|--|---|--|---|--|
| <input type="checkbox"/> Headache    | <input type="checkbox"/> Irritability        | <input type="checkbox"/> Numbness in Toes       | <input type="checkbox"/> Face Flushed        | <input type="checkbox"/> Feet Cold          | <input type="checkbox"/> Neck Pain     |
| <input type="checkbox"/> Chest Pain  | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Buzzing in Ears        | <input type="checkbox"/> Hands Cold          | <input type="checkbox"/> Neck Stiff         | <input type="checkbox"/> Dizziness     |
| <input type="checkbox"/> Fatigue     | <input type="checkbox"/> Loss of Balance     | <input type="checkbox"/> Stomach Upset          | <input type="checkbox"/> Sleeping Problems   | <input type="checkbox"/> Heavy Head Feeling | <input type="checkbox"/> Depression    |
| <input type="checkbox"/> Fainting    | <input type="checkbox"/> Constipation        | <input type="checkbox"/> Back Pain              | <input type="checkbox"/> Pins & Needles Arms | <input type="checkbox"/> Lights Bother Eyes | <input type="checkbox"/> Loss of Smell |
| <input type="checkbox"/> Cold Sweats | <input type="checkbox"/> Nervousness         | <input type="checkbox"/> Pins & Needles in Legs | <input type="checkbox"/> Loss of Memory      | <input type="checkbox"/> Loss of Taste      | <input type="checkbox"/> Fever         |
| <input type="checkbox"/> Tension     | <input type="checkbox"/> Numbness in Fingers | <input type="checkbox"/> Ears Ring              | <input type="checkbox"/> Diarrhea            | <input type="checkbox"/> Other (add below)  |  |

Symptoms Other Than Above: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What are your PRESENT complaints and symptoms? \_\_\_\_\_

Do you have any previous illnesses which relate to this case? \_\_\_\_\_ ( ) Yes ( ) No

If yes, please describe: \_\_\_\_\_

Did you have any physical complaints BEFORE THE ACCIDENT? ( ) Yes ( ) No

If yes, please describe in detail: \_\_\_\_\_

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

If yes, please describe, including date(s) and type(s) of accidents, as well as injuries received. \_\_\_\_\_

Have you lost time from work as a result of this accident? ( ) Yes ( ) No (If yes, please complete below)

a. Last Day Worked: \_\_\_\_\_

b. Type of Employment: \_\_\_\_\_

c. Are you being compensated for time lost from work? ( ) Yes ( ) No. (If yes, please complete below)

Type of compensation you are receiving? \_\_\_\_\_

Do you notice any activity restrictions as a result of this injury?( ) Yes ( ) No (If yes, please complete below) \_\_\_\_\_

Other pertinent information: \_\_\_\_\_

Have you contacted an adjuster regarding this claim?

Company: \_\_\_\_\_

Address: \_\_\_\_\_ Phone # \_\_\_\_\_

Adjuster: \_\_\_\_\_ Claim#: \_\_\_\_\_

**ASSIGNMENT OF BENEFITS and MEDICAL RELEASE**

**ASSIGNMENT OF BENEFITS**

I, \_\_\_\_\_, hereinafter ASSIGNOR, hereby authorize  
(Name of insured patient)

\_\_\_\_\_ to pay directly to **Bartz Chiropractic, LLC**  
(Name of Insurance Carrier) (Name of Medical Provider)

hereinafter ASSIGNEE, the medical benefits other wise payable to me for their services, but not to exceed the charges of those services. I hereby ASSIGN to ASSIGNEE any benefits or causes of action under any policy of insurance, indemnity agreement, or any other collateral source as defined in Florida Statutes for any service and or charges provided by ASSIGNEE. This ASSIGNMENT OF BENEFITS is given in exchange for ASSIGNEE agreeing to send request for payment to the above named insurance carrier for all payments due and payable pursuant to the ASSIGNOR'S contract of insurance. This ASSIGNMENT OF BENEFITS is IRREVOCABLE unless subsequent revocation is in writing and agreed to by both parties.

**MEDICAL RELEASE**

This document shall be sufficient to authorize any person having records of medical treatment, services, or supplies pertaining to me, to release true copies of same to ASSIGNEE or any insurer providing coverage to me in connection with the processing of any claim for benefits made by the ASSIGNEE herein. A photocopy of this document shall be as binding as an original signature page.

IN WITNESS WHERE OF the undersigned ASSIGNOR and ASSIGNEE have hereunto set their hands, this  
\_\_\_\_\_ day of \_\_\_\_\_, 20\_\_ .

\_\_\_\_\_  
Patient's Signature (ASSIGNOR)

\_\_\_\_\_  
Authorized Representative of ASSIGNEE

\_\_\_\_\_  
Patient's Name (Please Print Clearly)

**Auto Accidents:**

I authorize the release of PIP/Med. payment records to Bartz Chiropractic, LLC.

I authorize Bartz Chiropractic, LLC the right to obtain my Declaration Page of my Auto Policy.

\_\_\_\_\_  
Patient Name (Please Print Clearly)

\_\_\_\_\_  
Patient/Guardian Signature

\_\_\_\_\_  
Date