IRVING PARK CHIROPRACTIC CENTER

AUTO ACCIDENT

Date of Injury/accident____

Patient's auto insurance company name________________________________

Claim number____________________________

Adjuster's Name______________________________

Adjuster's telephone & fax number____

Mailing address to send bills______________________________________
____

Med Pay limit $______________

Accident report copy __Y__N___

What other doctor, including emergency room, have you been to__________________
____
____

Does patient have X-Rays __Y__N__

1923 W. Irving Park Rd. Chicago IL 60613 Phone 773-880-0880 Fax 773-880-0880

IRVING PARK CHIROPRACTIC CENTER

Thank you for choosing Irving Park Chiropractic Center. To help us complete our records and submit accurate bills to your insurance company, please assist us by providing the following information. If you have any questions about these forms the receptionist will gladly help you.

Today's Date:______________________ Patient's Social Security # ______________________________
First Name: ________________________ M.I. _____ Last Name: ______________________________
Date of Birth: ______________________ Sex: ❑M ❑F
Address: ____
City:______________________________ State:______________ Zip Code: ____________________
Home Phone: (______)________________ Work Phone: (______)________________
Cell Phone: (______)_________________ Pager: (______)_____________________
Email: ________________________________

How did you find us?: ❑Friend / Family Member (Name)____
❑Yellow Pages ❑Website ❑Insurance Provider Directory ❑Clinic Location
❑Presentation (Where & When)____
❑Other (Please Describe)____

I, the undersigned, hereby authorize the staff to perform such services as deemed necessary by the physician to diagnose and treat my condition(s). Further, I authorize assignment of my Insurance rights and benefits directly to this provider and also release of such information as is needed to process Insurance claims by provider or agent. I understand that I am responsible for all charges which may include legal fees, collection fees or other expenses incurred by the provider in collecting my account. I hereby order all parties to accept a copy of this release and assignment in lieu of the original. This shall remain in effect until revoked by me in writing.

☞**Patient Signature: ___________________________________ Date:___________________________**

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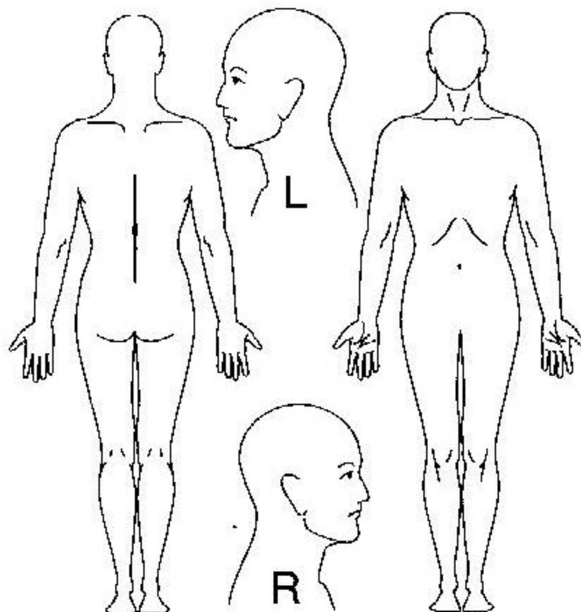
Patient's Name:___________________________ Date:______________________

Case Number:_______________

Please **Mark** your painful spots on the chart. Use the following symbols to describe the pain.

Burning: ********** Sharp/Stabbing: //////////// Aching: ooooooooo Dull: ~~~~~~~~



1. Pain right now 1 ---10

2. Average pain 1 ---10

3.Pain at its best 1 ---10

4.Pain at its worst 1 ---10

Percentage of time pain is at its worst _____%

Percentage of time pain is at its best _____%

Patient Signature:_________________________________

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IRVING PARK CHIROPRACTIC CENTER

AUTOMOBILE ACCIDENT QUESTIONNAIRE

Patient's Name:_____________________________ Today's Date:__________

Date of Accident:____________________________

THE FOLLOWING QUESTIONS PERTAIN TO YOU AND THE VEHICLE YOU WERE IN:

Vehicle type:
❑Car ❑Pickup
❑Van ❑Truck
❑Station Wagon
❑Other________________

Vehicle size:
❑Subcompact ❑Full-size
❑Compact ❑Mini
❑Bus ❑Mid-size ❑Light
❑Heavy ❑Other_________________

Your position in the vehicle:
❑Driver
❑Passenger -------- Location-------- ❑Left ❑Middle ❑Right
❑Other _________________ ❑Front Passenger ❑Rear Passenger ❑Third Seat (rear)

Speed of your vehicle:
❑Stopped ❑Moving Moderately
❑Parked ❑Moving Fast
❑Slowing ❑Moving at apprx ____MPH
❑Moving Slowly

Why Vehicle was slowed or stopped:
❑Traffic Signal ❑Parking
❑Pedestrian ❑Traffic
❑Stop Sign ❑Busy Intersection

Collision Type:
❑Driver Side Impact ❑Head On Collision
❑Passenger Side Impact ❑Rear Impact
❑Front Impact ❑Pedestrian Incident

THE FOLLOWING QUESTIONS CONCERN THE OTHER VEHICLE INVOLVED IN THE ACCIDENT:

Vehicle type:
❑Car ❑Pickup
❑Van ❑Truck
❑Station Wagon ❑Bus
❑Other________________

Vehicle size:
❑Subcompact ❑Full-size
❑Compact ❑Mini
❑Mid-size ❑Light
❑Heavy ❑Other_________________

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CONDITIONS AT THE TIME OF THE ACCIDENT:

Time of day:
- ❑Full daylight
- ❑Dusk
- ❑Night

Road Conditions:
- ❑Dry
- ❑Damp
- ❑Wet
- ❑Snow covered
- ❑Ice covered
- ❑Patchy Ice/Snow

Visibility:
- ❑Excellent
- ❑Good
- ❑Fair
- ❑Poor

Visibility compromised by:
- ❑Brightness
- ❑Darkness
- ❑Rain
- ❑Snow
- ❑Fog
- ❑Traffic

THE FOLLOWING QUESTIONS CONCERN THE MOMENT OF IMPACT OF THE ACCIDENT:

Were you...
- ❑Totally unaware that the accident was impending
- ❑Aware that the accident was impending
- ❑Aware that the accident was impending and braced for it

Restraints: (check all that apply)
- ❑Seat belt
- ❑Shoulder harness
- ❑No restraints

If you were the driver of the vehicle, was your foot on the brake pedal? ❑Yes ❑No ❑Knocked off by impact

Was the air bag deployed?
- ❑Car not equipped with air bag
- ❑Air bag deployed
- ❑Air bag not deployed

What position was YOUR headrest in?
- ❑High position
- ❑Middle position
- ❑ Low position

Position of YOUR head at time of impact?
- ❑Facing straight ahead
- ❑Tilted forward
- ❑Rotated to the left
- ❑Rotated to the right

Was your head thrown...?
- ❑Backward and then forward
- ❑Forward then backward
- ❑To the left
- ❑To the left then the right
- ❑To the right
- ❑To the right, then the left

Position of Your body at time of impact?
- ❑Straight
- ❑Tilted forward
- ❑Rotated to the left
- ❑Rotated to the right

Was your body thrown...?
- ❑Backward and then forward
- ❑Forward then backward
- ❑To the left
- ❑To the left then the right
- ❑To the right
- ❑To the right, then the left
- ❑Across ❑Outside ❑Under vehicle

Damage to vehicle YOU were in:
- ❑Incurred minimal damage
- ❑Incurred moderate damage
- ❑Incurred severe damage
- ❑Was totalled
- ❑Not known

Citations:
- ❑None issued
- ❑Yourself
- ❑Driver of vehicle patient was a passenger of
- ❑Driver of other vehicle
- ❑Not sure

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AS A RESULT OF THE FORCE OF THE COLLISION, ***WHICH OBJECTS IN THE VEHICLE DID YOUR BODY STRIKE****?*

Head

- ❑Steering wheel
- ❑Dashboard
- ❑Windshield
- ❑Armrest
- ❑Headrest
- ❑Rear view mirror
- ❑Left door
- ❑Right door
- ❑Left window
- ❑Right window
- ❑Console
- ❑Gear shift
- ❑Front seat
- ❑Backseat

Left Arm

- ❑Steering wheel
- ❑Dashboard
- ❑Windshield
- ❑Armrest
- ❑Headrest
- ❑Rear view mirror
- ❑Left door
- ❑Right door
- ❑Left window
- ❑Right window
- ❑Console
- ❑Gear shift
- ❑Front seat
- ❑Backseat

Right Arm

- ❑Steering wheel
- ❑Dashboard
- ❑Windshield
- ❑Armrest
- ❑Headrest
- ❑Rear view mirror
- ❑Left door
- ❑Right door
- ❑Left window
- ❑Right window
- ❑Console
- ❑Gear shift
- ❑Front seat
- ❑Backseat

Torso

- ❑Steering wheel
- ❑Dashboard
- ❑Windshield
- ❑Armrest
- ❑Headrest
- ❑Rear view mirror
- ❑Left door
- ❑Right door
- ❑Left window
- ❑Right window
- ❑Console
- ❑Gear shift
- ❑Front seat
- ❑Backseat

Left Leg

- ❑Steering wheel
- ❑Dashboard
- ❑Windshield
- ❑Armrest
- ❑Headrest
- ❑Rear view mirror
- ❑Left door
- ❑Right door
- ❑Left window
- ❑Right window
- ❑Console
- ❑Gear shift
- ❑Front seat
- ❑Backseat

Right Leg

- ❑Steering wheel
- ❑Dashboard
- ❑Windshield
- ❑Armrest
- ❑Headrest
- ❑Rear view mirror
- ❑Left door
- ❑Right door
- ❑Left window
- ❑Right window
- ❑Console
- ❑Gear shift
- ❑Front seat
- ❑Backseat

THE FOLLOWING QUESTIONS CONCERN THE TIME PERIOD **IMMEDIATELY FOLLOWING THE ACCIDENT**:

Did you lose consciousness? ❑Yes ❑No

Immediately following the accident, did you feel...?

- ❑Dizzy
- ❑Dazed
- ❑Disoriented
- ❑Weak
- ❑Nervous
- ❑Nauseated

Were you able to walk unaided? ❑Yes ❑No

Where did you go...?

- ❑Drove home
- ❑Was driven home
- ❑Drove to hospital
- ❑Was driven to hospital
- ❑Taken to hospital via ambulance
- ❑Drove to work
- ❑Was driven to work
- ❑Drove to school
- ❑Was driven to school
- ❑Other (Describe) ________________

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Next day discomfort...? ❑Yes ❑ No

Did your major complaints exist before the accident? ❑Yes ❑ No

In what areas did you IMMEDIATELY feel pain?

Head	❑L ❑R	Shoulder	❑L ❑R	Hip	❑L ❑R
Neck	❑L ❑R	Arm	❑L ❑R	Thigh	❑L ❑R
Upper back	❑L ❑R	Elbow	❑L ❑R	Knee	❑L ❑R
Mid back	❑L ❑R	Wrist	❑L ❑R	Calf	❑L ❑R
Ribs	❑L ❑R	Hand	❑L ❑R	Ankle	❑L ❑R
Chest	❑L ❑R	Fingers	❑L ❑R	Foot	❑L ❑R
Abdomen	❑L ❑R	Buttock	❑L ❑R	Toes	❑L ❑R
Low Back	❑L ❑R	Pelvis	❑L ❑R		

In what areas did you experience lacerations (cuts)?

Head	❑L ❑R	Shoulder	❑L ❑R	Hip	❑L ❑R
Neck	❑L ❑R	Arm	❑L ❑R	Thigh	❑L ❑R
Upper back	❑L ❑R	Elbow	❑L ❑R	Knee	❑L ❑R
Mid back	❑L ❑R	Wrist	❑L ❑R	Calf	❑L ❑R
Ribs	❑L ❑R	Hand	❑L ❑R	Ankle	❑L ❑R
Chest	❑L ❑R	Fingers	❑L ❑R	Foot	❑L ❑R
Abdomen	❑L ❑R	Buttock	❑L ❑R	Toes	❑L ❑R
Low Back	❑L ❑R	Pelvis	❑L ❑R		

At the hospital, what areas were x-rayed?

Head	❑L ❑R	Shoulder	❑L ❑R	Hip	❑L ❑R
Neck	❑L ❑R	Arm	❑L ❑R	Thigh	❑L ❑R
Upper back	❑L ❑R	Elbow	❑L ❑R	Knee	❑L ❑R
Mid back	❑L ❑R	Wrist	❑L ❑R	Calf	❑L ❑R
Ribs	❑L ❑R	Hand	❑L ❑R	Ankle	❑L ❑R
Chest	❑L ❑R	Fingers	❑L ❑R	Foot	❑L ❑R
Abdomen	❑L ❑R	Buttock	❑L ❑R	Toes	❑L ❑R
Low Back	❑L ❑R	Pelvis	❑L ❑R		

Where did you experience pain on the day FOLLOWING the accident?

Head	❑L ❑R	Shoulder	❑L ❑R	Hip	❑L ❑R
Neck	❑L ❑R	Arm	❑L ❑R	Thigh	❑L ❑R
Upper back	❑L ❑R	Elbow	❑L ❑R	Knee	❑L ❑R
Mid back	❑L ❑R	Wrist	❑L ❑R	Calf	❑L ❑R
Ribs	❑L ❑R	Hand	❑L ❑R	Ankle	❑L ❑R
Chest	❑L ❑R	Fingers	❑L ❑R	Foot	❑L ❑R
Abdomen	❑L ❑R	Buttock	❑L ❑R	Toes	❑L ❑R
Low Back	❑L ❑R	Pelvis	❑L ❑R		

Patient's Signature:____

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RESCISSION OF ATTORNEY ASSIGNMENT OF BENEFITS

Date Sent: ______________________

Sent By: ______________________

Patient: ________________________________

Insured: ________________________________

Date of Injury: __________________________

Claim # / Policy #: ______________________

Social Security #: ______-_____-________

I, being the insured on this policy, specifically direct you, my insurance company to rescind and cancel any assignment given to you by any third party including my attorney, EXCEPT to my physician.

Dr. Max N. Lazarowich

2145 W. Irving Park Rd
Chicago, IL, 60618
Tel. 773.539.0220
Fax. 773.539.0221

As the owner and beneficiary of this policy, I further direct that reimbursement for ALL services be paid DIRECTLY to my physician, the provider of services, under the terms of my contract with this company. NO other third party, including my attorney, should receive payment of my medical bills, except the treating physician for the remainder of this claim.

Thank you for your cooperation in this matter.

____
Patient / Insured Signature

IRVING PARK CHIROPRACTIC CENTER

THIRD PARTY MEDICAL LIEN AND ASSIGNMENT

PATIENT: ____
CLAIM #: ___________________
DATE OF INJURY: ___________________

I hereby authorize and direct ________________________________ Insurance Company, to pay to Dr. Max N. Lazarowich such sums as may be due and owing him/her for medical/chiropractic services rendered me by reason of the accident and to withhold such sums from any settlement, judgment, or verdict as may be necessary to adequately protect and fully compensate said doctor. And I hereby further request that payment be made directly to said doctor, which would otherwise be paid to myself, as the result of treatment charges incurred for injuries in connection therewith. This is a direct assignment of my rights and benefits under this claim.

I fully understand that I am directly and fully responsible to said doctor for all medical bills submitted by him for services rendered me and that this agreement is made solely for said doctor's protection and in consideration of his awaiting payment. And I further understand that such payments are not contingent on any settlement, judgment, or verdict, which I may eventually recover.

Please acknowledge your agreement to this request by signing below and returning to the doctor's office below. I have been advised that if you don't wish to cooperate in protecting the doctor's interest, the doctor will not await payment, but may declare the entire balance due and payable by me.

___________________ ______________________________________

Date Patient's Signature

The undersigned Insurance Company does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgment or verdict, as may be necessary to adequately protect and fully compensate said doctor above and below named and make payment payable directly to said doctor.

____________________________ ________________________________

Date Signature of Insurance Company Representative

____________________________ ________________________________

Print Full Name Insurance Company Name

Please date, sign and return one copy to the doctor's office below.

Irving Park Chiropractic
2145 W. Irving Park
Chicago, IL 60618
773.539.0220