Automobile Accident History Form

Dr. Corinne A Kennedy of Kennedy Chiropractic Center

11515 W. North Avenue -Ste. A- Wauwatosa, WI 53226

414-443-1515

PLEASE CIRCLE ALL THAT APPLY

Date Of Accident:_____/_____/_____ Time Of Accident: _____:_____am/pm Daylight Dawn Dusk Dark

Road Conditions At The Time Of The Accident: Wet Dry Snow Ice Other_____

Was The Accident On The Job? Yes No Were You In A Company Vehicle? Yes No

Where Were You Seated In The Vehicle? Driver Passenger Rear-Seat Other_____

Were You Aware Of The Approaching Collision Prior To Impact, Or Did It Catch You By Surprise? Aware Surprise

Did You Loose Consciousness Upon Impact? Yes No

What Were Your Initial Symptoms? None - Headache - Dizzy - Disoriented - Shock - Neck Pain -Back Pain -Other_____

What Were Your Symptoms The Next Day?_____

Have You Been In Any Prior Accidents? (If Yes, Please Explain)_____

Did The Police Come To The Accident Scene? Yes No

PLEASE CIRCLE ALL THAT APPLY

Were You Wearing A Seatbelt? Yes No If Yes, Did You Receive Any Injury Or Bruising From Seatbelt? Yes No

Did Your Head Hit The Headrest During Impact? Yes No Was The Position Of The Headrest Altered? Yes No

Was The Seat Adjustment Altered During Impact? Yes No Was The Seat Broken During The Accident? Yes No

Did The Air Bag Deploy? Yes No If Yes, Did It Strike You? Yes No If Yes, Where?_____

Which Way Was Your Head Pointing At The Time Of Impact? Straight Right Left / Your Body? Straight Right Left

Where Were Your Hands? One On The Wheel Both On The Wheel Does Not Apply

Were You Wearing Glasses Or A Hat At The Time Of Impact? Yes No If Yes, Were They Still On After The Accident? Yes No

PLEASE CIRCLE ALL THAT APPLY

Did You Go To The Hospital? Yes No When? Immediately Hours Later Days Later Which Hospital?_____

How Did You Get To The Hospital?_____ Were You Admitted? Yes No

What Were The Hospitals Findings?_____

YOUR CAR

List The Year, Make And Model Of The Car You Were In: Year_____Make_____Model_____

Was Your Car Stopped At The Time Of Impact? Yes No If Yes, Was The Drivers Foot On The Brake Yes No

Was Your Vehicle Moving At The Time Of Impact? Yes No If Yes, At Approximately What Speed_____MPH

OTHER CAR

List The Year, Make And Model Of The Other Car: Year_____Make_____Model_____

Was The Other Car Moving At The Time Of Impact? Yes No If Yes, At Approximately What Speed?_____MPH

At The Time Of Impact, Was The Other Care: Slowing Down Gaining Speed Steady Speed

Name Of Patients Auto Insurance_____

Address_____

Claim #_____

Adjuster's Name_____

Adjuster's Phone Number_____

Name Of At Fault Person's Auto Insurance_____

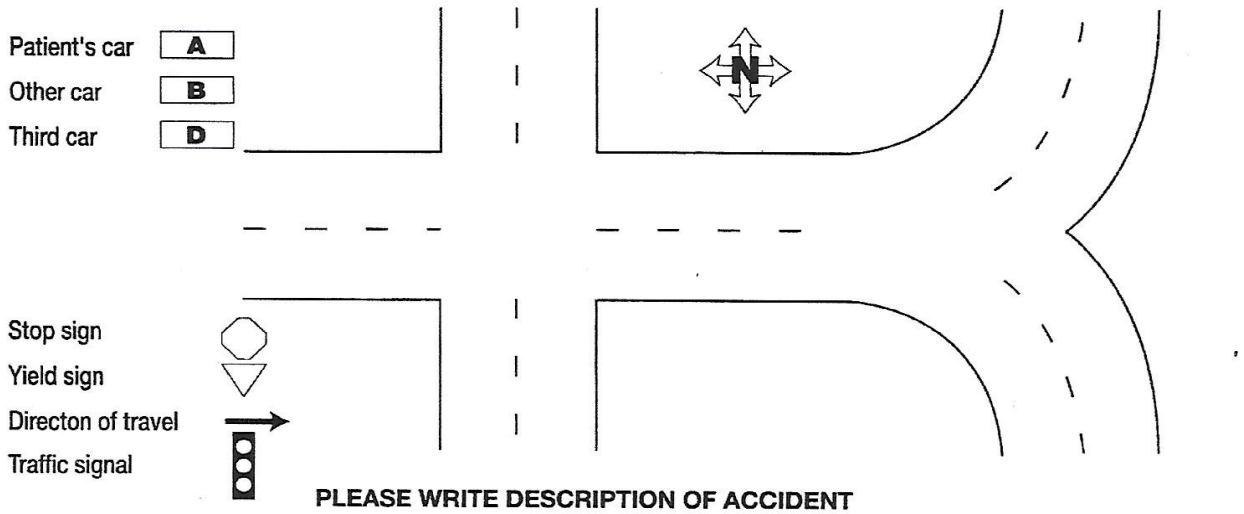
Address_____

Claim #_____

Adjuster's Name_____

Adjuster's Phone Number_____

PLEASE DRAW A DIAGRAM OF THE ACCIDENT



PLEASE WRITE DESCRIPTION OF ACCIDENT

(Include street names)

NON RESCINDABLE AGREEMENT LETTER

Name of Attorney_____Phone #_____

This agreement is between Dr. Corinne A Kennedy and_____

And any third party involved in the accident on _____

I_____do hereby authorize and agree to pay any outstanding balance due on my account at the time of my release from care.

I promise that any monies due from my personal injury protection will be paid directly to Dr. Corinne A Kennedy.

I promise to have my attorney pay in full any outstanding monies due to Dr. Kennedy at that time of my settlement with any liability claims that result from the case. My attorney shall NOT withhold any portion of the amount due to Dr. Kennedy under this agreement to offset attorney's fees, which my attorney now or hereafter may claim to be owed by me. I promise to have my attorney pay Dr. Kennedy immediately upon settlement, by way of issuance of a separate draft made payable to Kennedy Chiropractic Center.

I promise to have any third party individual or insurance carrier that may be liable, to pay Dr. Corinne A Kennedy direct for any outstanding medical bills which are the result of this accident. If payment is not made until time of settlement, I will instruct the third party to issue a separate draft to be payable to Kennedy Chiropractic Center.

I understand and acknowledge that all charges incurred by me are my responsibility regardless of any settlement made by a third party. I am instructing and agreeing to the above conditions as a safeguard to Dr. Corinne A Kennedy's right to collect payment. I understand that Dr. Corinne A Kennedy has the right to expect good faith payments on my account and that a full payment in being deferred only until such time as a third party settlement occurs. If a settlement does not occur within a reasonable amount of time, I agree to make other arrangements to pay my account in full.

Patients Signature:_____ Date: _____/_____/_____