

Roper Chiropractic Clinic, P.A.
137 N. Main Street, Fuquay-Varina, NC 27526

AUTOMOBILE ACCIDENT QUESTIONNAIRE

Patient Name:							
Date & Time of Accident:							
Location of Accident:							
Describe briefly how accident happened:							
Were you wearing your seatbelt ?		Did your airbag deploy?		Was your headrest up?		Your speed	Other car speed
Estimate of damage to your car ?	\$	How much damage to other car ?		\$			
Were you:		_____ Driver _____ Passenger _____ Pedestrian					
If passenger, where were you sitting?							
Were you struck from:		_____ Behind _____ Front _____ Left Side _____ Right Side					
List your injuries as you know them:							
Have you ever had complaints with this area before? _____ Yes _____ No							
Were you taken to a <u>doctor's</u> office or <u>hospital</u> , if so which one?							
If you were admitted to the hospital, how many days were you there?							
Have you been back to the doctor? If so, which one?							
Have you had x-rays? If so, where?							
List medications you were prescribed for your pain, if any:							
Were you knocked unconscious? If yes, how long? _____		Yes _____ No _____					
Are you seeing another doctor for this condition ? _____ Yes _____ No							
Have you lost any time from work as a result of this accident? _____ Yes _____ No							
If so, please give dates _____ .							
Have you returned to work? _____ Yes _____ No							
Have you ever been injured in an automobile accident before? _____ Yes _____ No							
If yes, give date(s): _____							
Patient's Signature						Date:	

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James P. Roper, DC

137 North Main St
Fuquay-Varina, NC 27526

Phone: 919-577-2225
Fax: 919-577-2226

PERSONAL INJURY (AUTO ACCIDENT) INFORMATION NEEDED

Date of Accident: _____

Name/Address of <u>Other Party</u> (s):	
Name/Address of <u>Other Party's</u> Insurance Company:	
Phone No. of <u>their</u> Insurance Company:	
Claim Number:	
Adjuster Name:	
<u>Your</u> Lawyer name, address, phone if applicable:	

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Date of Accident: _____

Please call "your" car insurance company and ask them if you have "Med Pay" coverage on "your" policy. If you "do" have "Med Pay", please ask them for the following information:

Name & "Claims" Address of <u>your</u> car Insurance Company:	
Phone No. of <u>your</u> Insurance Company:	
Claim Number:	
Adjuster Name:	
Amount of Med Pay Coverage:	\$_____.00

Med Pay is "no fault" insurance that many people have on their car insurance. "No Fault" means there is medical coverage no matter who is at fault. It is to be used for health care costs related to a car accident. Our office will be glad to bill your Med Pay insurance company for you.

All you have to do is call "your" car insurance company and get the information requested above and bring it to our office. We will do the rest.

MAKING A CLAIM AGAINST YOUR MED PAY INSURANCE WILL NOT INCREASE YOUR CAR INSURANCE RATES.