

# ZEN Chiropractic Center

## Auto Accident Form

Date the accident/injury occurred: \_\_\_\_/\_\_\_\_/20\_\_\_\_

M D Year

Were you the driver? Yes , If not, were you the passenger at the

Front seat  Right backseat  Left backseat  Middle backseat  Other \_\_\_\_\_

Patient's Name \_\_\_\_\_ Insured's Name (if not the same as patient) \_\_\_\_\_

Relationship to Insured  Spouse  Child  Other, explain \_\_\_\_\_

Insurance Co. Name : \_\_\_\_\_ Insured's ID # \_\_\_\_\_ Group # \_\_\_\_\_

Claim # \_\_\_\_\_

Please describe the accident and the location \_\_\_\_\_

When did the symptoms first appeared ? \_\_\_\_/\_\_\_\_/\_\_\_\_

Have you had the same or similar symptoms?  Yes  No If yes, please explain

Did you Loss consciousness?  Yes, how long ? \_\_\_\_\_  No

Were you disabled?  Yes, from \_\_\_\_/\_\_\_\_/\_\_\_\_ thru \_\_\_\_/\_\_\_\_/\_\_\_\_  No

Were you hospitalized? Yes \_\_\_ No \_\_\_ Period of hospitalization \_\_\_\_/\_\_\_\_/\_\_\_\_ thru \_\_\_\_/\_\_\_\_/\_\_\_\_

### **Please Present Your Insurance Card and Driver's License to be Photocopy.**

#### **Assignment & Release**

I, the undersigned, have insurance coverage with \_\_\_\_\_ and assign directly to Zen

Name of Insurance Company

Chiropractic Center all medical benefits, if any, otherwise payable to me for service render. I understand that I am financially responsible for all charges whether or not pay by my insurance. I here by authorize the office to release all information necessary to secure payment of benefits. I authorize the use of this signature on all my insurance submission.

\_\_\_\_\_  
Signature of Insured/Guardian

\_\_\_\_\_  
Date