

IF YOURS IS AN ACCIDENTAL INJURY PLEASE COMPLETE THE FOLLOWING QUESTIONS

Date of Accident _____ Hour _____ AM _____ PM Location _____

How did Accident Occur? Auto Collision On the job Injury Other _____

If not an auto collision, please describe the circumstances: _____

Did you report the injury to your foreman or employer? YES NO

Did he/she (they) recommend care at our office YES NO

If auto accident, were you Driver Passenger Pedestrian

If auto collision, were you struck from Behind Right Side Left Side Front Auto was Parked

Did your car strike the other(s) involved? YES NO Undetermined

OR did the other car strike yours? YES NO

As a result of the accident, were traffic citations issued to you? YES NO

To the driver of the other car? YES NO

To the driver of your car? YES NO

List the extent of the injuries as you know them: _____

Did you require post accident hospitalization? YES NO

Check symptoms you have noticed since accident:

- | | | | |
|--------------------------------------------|---------------------------------------------------|---------------------------------------------|----------------------------------------|
| <input type="checkbox"/> Headache | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Light Bothers Eyes | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Head Seems Too Heavy | <input type="checkbox"/> Loss of Memory | <input type="checkbox"/> Feet Cold |
| <input type="checkbox"/> Neck Stiffness | <input type="checkbox"/> Pins and Needles in Arms | <input type="checkbox"/> Ears Ring | <input type="checkbox"/> Hands Cold |
| <input type="checkbox"/> Problems Sleeping | <input type="checkbox"/> Pins and Needles in Legs | <input type="checkbox"/> Face Flushed | <input type="checkbox"/> Stomach Upset |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Numbness in Fingers | <input type="checkbox"/> Buzzing in Ears | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Numbness in Toes | <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Cold Sweats |
| <input type="checkbox"/> Tension | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Fainting | <input type="checkbox"/> Fever |
| <input type="checkbox"/> Irritability | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Loss of Smell | <input type="checkbox"/> Chest Pain |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Toss of Taste | <input type="checkbox"/> Other: _____ | |

Symptoms other than above: _____

Have you lost any days of work? YES NO Dates: _____

Insurance Companies involved:

My Company: _____

Company of person responsible for injuries: _____

Have you been contacted by an insurance adjuster of company representative regarding this claim? YES NO

Do you have an attorney that has advised you in this case? YES NO

Attorney's Name: _____ Phone number: _____

Address: _____

Jones Rd. Chiropractic

Dr. Steven P. Buras

ASSIGNMENT OF BENEFITS AND LIEN

THE STATE OF TEXAS:

KNOW ALL MEN BY THESE PRESENTS:

COUNTY OF HARRIS:

In consideration of the Chiropractic services rendered and to be rendered by Dr. Steven P. Buras, I hereby give an irrevocable lien and power of endorsement to Dr. Steven P. Buras, on any benefits, settlement, claim, judgment or verdict arising from the injuries or illness for which I have been treated by Dr. Buras or his staff.

I hereby instruct my attorney and/or other entity responsible for payment of my treatment, including any third party insurance, to pay directly to Dr. Buras for services rendered to me and to withhold such sums from settlement, claim, judgment or verdict as may be necessary to compensate Dr. Buras for the services rendered on my behalf.

Under the terms and conditions of said policy, should I be entitled to any sums for lost wages or wage compensation benefits or reimbursement of necessary and reasonable expenses incurred for essential services ordinarily performed for the care and maintenance of the family or family household, then, in this event, I direct that such benefits be subordinated to the claims for Chiropractic services rendered by the above named Doctor and that such benefits for these Chiropractic services be paid prior to and in preference over claims by me for lost wages, wage continuation benefits or reimbursement for reasonable household services.

I fully understand that I am directly and fully responsible to Dr. Buras for all medical bills submitted. I further understand that such payment is not contingent upon any settlement, claim, judgment or verdict by which I may eventually recover. I understand that nothing herein shall in any way reduce or mitigate my obligation to pay and keep current all charges for Chiropractic services rendered.

I hereby authorize Dr. Steven P. Buras and his employees to disclose to said insurer such information concerning my medical condition as the insurer is entitled to under the terms of the policy.

Executed this the _____ day of _____, 20____.

A photostatic copy of this assignment shall be as valid as the original.

Signature