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:

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

Symptoms other that 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:_____

Personal Injury Verification

Date _____

Date of Injury _____ Date of 1st Treatment _____

Cause of Injury _____

_____

Patient _____ SS # _____

Address _____ D.O.B. _____

City _____ State _____ Zip _____

Phone # _____ Work # _____

P.I.P. Information

Insurance Co. _____ Claim # _____

Address _____

City _____ State _____ Zip _____

Adjuster _____ Phone # _____

Fax # _____

Third Party Information

Insurance Co. _____ Claim # _____

Address _____

City _____ State _____ Zip _____

Adjuster _____ Phone # _____

Fax # _____

Attorney Information

Name _____

Address _____

City _____ State _____ Zip _____

Phone # _____ Fax # _____

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

12218 Jones Road • Suite H • Houston, Texas 77070
281-807-9210 • FAX 281-807-9207