

DOCTOR'S LIEN

TO: Attorney / Insurance Carrier

Doctor:

RE.: Patient Records and Doctor's Lien

I do hereby authorize the above doctor to furnish you, my attorney/insurance carrier, with a full report of his case history, examination, diagnosis, treatment, and prognosis of myself in regard to my accident/illness which occurred/began on _____.

I hereby give a lien to said doctor on any settlement, claim, judgment, or verdict as a result of said accident/illness, and authorize and direct you, my attorney/insurance carrier, to pay directly to said doctor such sums as may be due and owing him for services rendered me, and to withhold such sums from such settlement, claim, judgment, or verdict as may be necessary to protect the said doctor adequately.

I fully understand that I am directly and fully responsible to said doctor for all Chiropractic bills submitted by him for services rendered me, and that this agreement is made solely for said doctor's additional protection and in consideration of his awaiting payment. And I further understand that such payment is not contingent on any settlement, claim, judgment, or verdict by which I may eventually recover said fee.

Dated: _____ Patient's Signature: _____

The undersigned, being attorney of record or authorized representative of insurance carrier for the above patient does hereby acknowledge receipt of the above lien, and does agree to honor the same to protect adequately the said above named doctor.

Dated: _____ Authorized Signature: _____

NOTICE: Please date, sign, and return one (1) copy to doctor's office at once.

VEHICLE ACCIDENT INFORMATION

| PATIENT INFORMATION | | | |
|---|---|--|---|
| Patient Name _____ | Date _____ | | |
| Date of Accident _____ | Time of Accident _____ | <input type="checkbox"/> a.m. | <input type="checkbox"/> p.m. |
| Please describe the accident in your own words: _____ _____ _____ | | | |
| Were you the: | <input type="checkbox"/> Driver | <input type="checkbox"/> Front Passenger | How many people were in the accident vehicle? _____ |
| | <input type="checkbox"/> Rear Passenger | <input type="checkbox"/> Pedestrian | |

| ACCIDENT SITE |
|--|
| Road/Street Name _____ |
| City/State _____ |
| Nearest intersection with road/street _____ |
| Driving conditions <input type="checkbox"/> Dry <input type="checkbox"/> Wet <input type="checkbox"/> Icy <input type="checkbox"/> Other _____ |
| Which direction were you headed? _____ |
| Speed you were traveling? _____ |

| IMPACT |
|--|
| Did your car impact another vehicle? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Did your car impact a structure? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| If yes, explain _____ |
| Did any part of your body strike anything in the vehicle? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain _____ |
| Was impact from : |
| <input type="checkbox"/> Front <input type="checkbox"/> Rear <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Other _____ |
| At the time of impact were you: |
| <input type="checkbox"/> Looking straight ahead <input type="checkbox"/> Looking to the right |
| <input type="checkbox"/> Looking to the left <input type="checkbox"/> Looking down |
| <input type="checkbox"/> Looking up |
| Were both hands on the steering wheel? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| If no, which hand was on the wheel? <input type="checkbox"/> Right <input type="checkbox"/> Left |
| Was your foot on the brake? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| If yes, which foot was on the brake? <input type="checkbox"/> Right <input type="checkbox"/> Left |
| Were you: <input type="checkbox"/> Surprised by impact <input type="checkbox"/> Braced for impact |

| VEHICLE |
|---|
| Make and model of vehicle you were in: _____ |
| Were you wearing a seatbelt? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| If yes, what type? <input type="checkbox"/> Lap <input type="checkbox"/> Shoulder |
| Was vehicle equipped with airbags? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| If yes, did it/they inflate properly? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Did your seat have a headrest? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| If yes, what was the position of the headrest? |
| <input type="checkbox"/> Low <input type="checkbox"/> Midposition <input type="checkbox"/> High |

| OTHER VEHICLE <small>(if applicable)</small> |
|---|
| Make and model of other vehicle _____ |
| Which direction was other vehicle headed? _____ |
| Speed other vehicle was traveling _____ |

| POLICE |
|--|
| Did the police come to the accident site? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Were there any witnesses? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Was a police report filed? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Was a traffic violation issued? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| If yes, to whom? _____ |

PATIENT CONDITION

Were you unconscious immediately after the accident? Yes No . If yes, for how long? _____

Please describe how you felt immediately after the accident:

TREATMENT

Did you go to the hospital? Yes No

When did you go? Immediately after accident Next day 2 days or more after the accident

How did you get to the hospital? Ambulance Private transportation

Name of hospital _____ Name of doctor _____

Diagnosis _____

Treatment received _____

X-rays taken _____

SYMPTOMS/INJURIES

Have you been able to work since this injury? Yes No How many work days have you missed? _____

Prior to the injury were you able to work on an equal basis with others your age? Yes No

If you have had any of the following symptoms since your injury, please check:

- | | | |
|--|---|--|
| <input type="checkbox"/> Arm/shoulder pain | <input type="checkbox"/> Feet/toe numbness | <input type="checkbox"/> Neck pain |
| <input type="checkbox"/> Back pain | <input type="checkbox"/> Hand/finger numbness | <input type="checkbox"/> Neck stiff |
| <input type="checkbox"/> Back stiffness | <input type="checkbox"/> Headaches | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Irritability | <input type="checkbox"/> Sleep difficulty |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Jaw problems | <input type="checkbox"/> Stomach upset |
| <input type="checkbox"/> Ear buzzing | <input type="checkbox"/> Leg pain | <input type="checkbox"/> Tension |
| <input type="checkbox"/> Ear ringing | <input type="checkbox"/> Memory loss | <input type="checkbox"/> Vision blurred |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Nausea | |

Is this condition getting progressively worse? Yes No Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

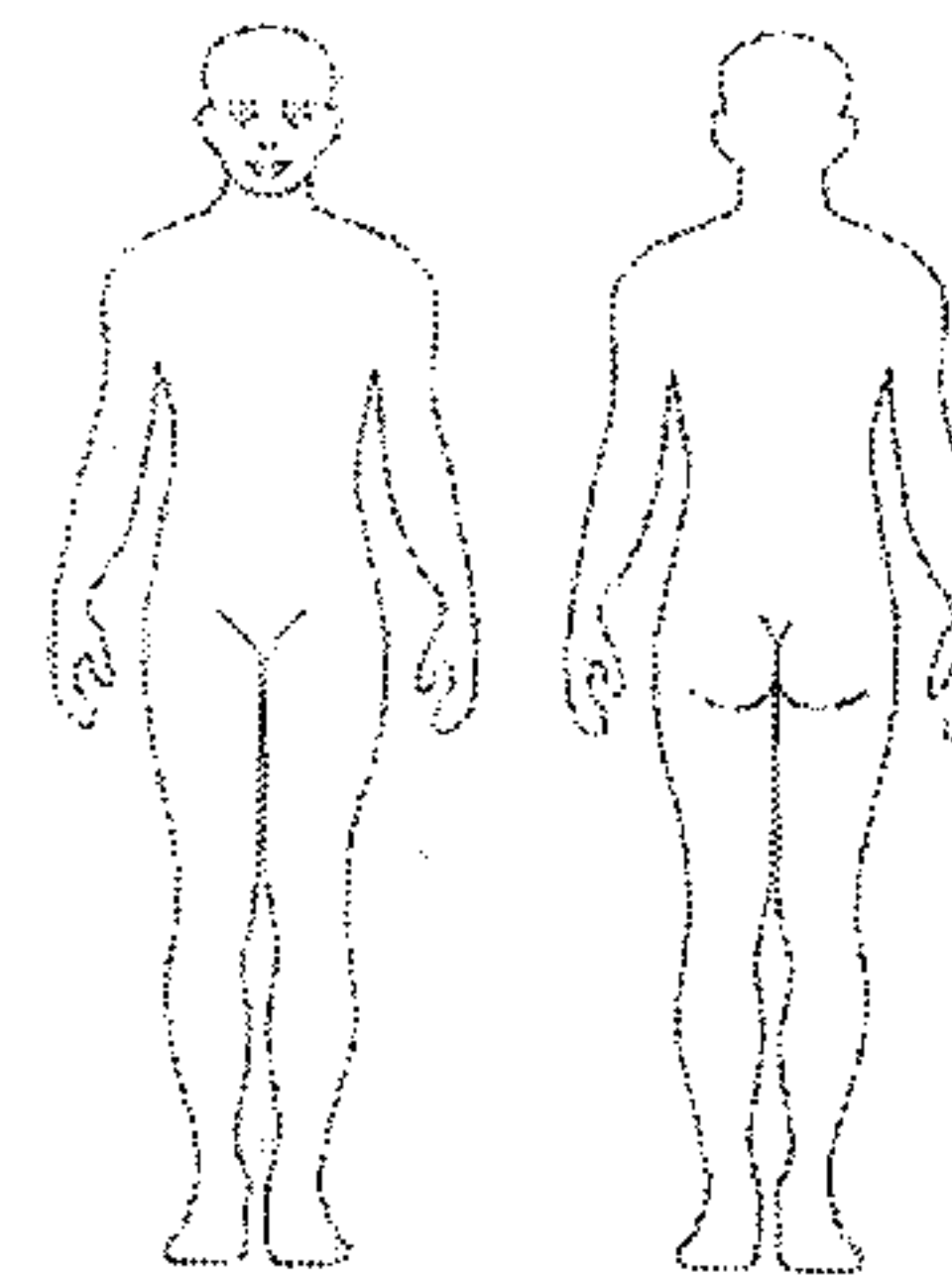
Type of pain: Sharp Dull Throbbing Numbness
 Aching Shooting Burning Tingling
 Cramps Stiffness Swelling Other _____

How often do you have this pain? _____

Is it constant or does it come and go? _____

Does it interfere with your: Work Sleep Daily Routine Recreation

Movements that are painful to perform: Sitting Standing Walking
 Bending Lying Down



To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

Signature of Patient, Parent, Guardian or Personal Representative

Date

Please print name of Patient, Parent, Guardian or Personal Representative

Relationship to Patient