Dakota Chiropractic
*making your health a priority*

INTERNAL USE ONLY
___CASE TYPE ___COVERAGE TYPE
___CONDITION TAB ___CLAIM#
___BATCH CLAIM ONLY ___TERM OTHER COVERAGE

# MOTOR VEHICLE ACCIDENT INTAKE FORM

## 1 ACCIDENT INFORMATION

FIRST NAME _____ LAST NAME _____

DATE OF ACCIDENT _____ TIME _____ ◯ AM ◯ PM LOCATION _____

**Were you:** ◯ DRIVER ◯ PASSENGER ◯ PEDESTRIAN

**Were you struck from:** ◯ BEHIND ◯ RIGHT SIDE ◯ LEFT SIDE ◯ FRONT ◯ PARKED

**Did your car strike others involved?** ◯ YES ◯ NO ◯ UNDETERMINED

**Did the other car strike yours?** ◯ YES ◯ NO ◯ UNDETERMINED

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

**Please describe the circumstances of the accident in detail:**

_____

_____

## 2 ACCIDENT SYMPTOMS

**Did you require post-accident hospitalizations or an emergency room visit?** ◯ YES ◯ NO

**Check symptoms you have noticed since the accident.**

- ◯ Headaches
- ◯ Neck Pain
- ◯ Neck Stiff
- ◯ Dizziness
- ◯ Back Pain
- ◯ Nervousness
- ◯ Tension
- ◯ Irritability
- ◯ Chest Pain
- ◯ Sleeping Problems
- ◯ Head Too Heavy
- ◯ Pins & Needles in Arms
- ◯ Pins & Needles in Legs
- ◯ Numbness in Fingers
- ◯ Numbness in Toes
- ◯ Shortness of Breath
- ◯ Fatigue
- ◯ Depression
- ◯ Lights Bother Eyes
- ◯ Loss of Memory
- ◯ Ears Ringing
- ◯ Face Flushed
- ◯ Buzzing in Ears
- ◯ Loss of Balance
- ◯ Fainting
- ◯ Loss of Smell
- ◯ Loss of Taste
- ◯ Diarrhea
- ◯ Cold Feet
- ◯ Cold Hands
- ◯ Stomach Upset
- ◯ Constipation
- ◯ Cold Sweats
- ◯ Fever
- ◯ Other

## 3 INSURANCE INFORMATION

**Personal Policy:**

INSURANCE COMPANY _____

ADDRESS _____

POLICY# _____

AGENT'S NAME | PHONE _____

CLAIM# _____

**Responsible Party:**

INSURANCE COMPANY _____

ADDRESS _____

POLICY# _____

AGENT'S NAME | PHONE _____

CLAIM# _____

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

If yes, attorney's name & address _____

*Dakota Chiropractic has my permission to share information with appropriate parties in order to process claims.*

PATIENT/PARENT/GUARDIAN NAME (PRINT) _____ PATIENT/PARENT/GUARDIAN SIGNATURE _____ DATE _____