Office Name: _____

Doctor(s) Name:_____

Practice Member Name:

Date of Accident: _____ Time of Accident:_____ City:_____ State:_____

Please contact YOUR car insurance company and obtain the following information.

Do you have Medical Pay on your Policy? YES NO
If Yes, coverage amount: $1,000 $2,000 $5,000 $10,000 $_____

Is your Medical Pay primary? YES NO

Personal Injury Claim #: _____

Personal Injury Adjuster's Name:_____

Adjusters Phone Number: _____Extension_____

Insurance Company Name, Address & Fax Number:

_____

_____

_____

Fax Number: _____

Attorney Information

Have you retained an attorney? YES NO

Attorney Name: _____Firm: _____

Phone Number: _____Fax: _____

Other Driver (At Fault Driver) Insurance Information

Name: _____ Claim #: _____

At Fault Driver's Insurance Company Name & Address

_____

_____

_____

Personal Injury Adjuster's Name:_____

Adjusters Phone Number: _____Extension_____

At Fault States: Alabama, Alaska, Arizona, Arkansas, California, Colorado, Connecticut, Delaware, Georgia, Idaho, Illinois, Indiana, Iowa, Louisiana, Maine, Maryland, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Mexico, North Carolina, Ohio, Oklahoma, Oregon, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Vermont, Virginia, Washington, West Virginia, Wisconsin & Wyoming

Cornerstone Chiropractic
2510 W. Chestnut, Suite F
580-540-3357

NOTICE OF DOCTOR'S LIEN

I hereby authorize and instruct my attorney &/or insurance carrier,_____ to pay **CORNERSTONE CHIROPRACTIC** directly for the full amount of services rendered by **CORNERSTONE CHIROPRACTIC** in relation to my personal injury treatment arising from my accident on or about _____ once a settlement or verdict is reached and those funds are made available or disbursed.

I understand that I am directly and fully responsible for all medical bills incurred at **CORNERSTONE CHIROPRACTIC** for services rendered to me with respect to any personal injury treatment. Further, I understand that I am responsible for the payment of all services rendered by **CORNERSTONE CHIROPRACTIC**, regardless of whether or not I receive any proceeds from any insurance company or third party, and that my obligation and liability to **CORNERSTONE CHIROPRACTIC** is in no way conditioned upon any settlement of verdict.

I agree to promptly notify **CORNERSTONE CHIROPRACTIC** of any changes in my representation or attorney for this accident.

By signing below I acknowledge and agree to this lien in favor of **CORNERSTONE CHIROPRACTIC** the full amount owed for any and all services rendered to me by **CORNERSTONE CHIROPRACTIC.**

I acknowledge that **CORNERSTONE CHIROPRACTIC** is not required to permit me the option to postpone or make payments toward of services rendered, and that it is being done solely as a courtesy. As such, **CORNERSTONE CHIROPRACTIC** may, at any time, seek payment for any and all amounts owed by me while this lien is in force. Additionally, if my attorney fails to acknowledge this lien in favor of **CORNERSTONE CHIROPRACTIC**, the entire balance related to this personal injury treatment is my sole responsibility, and **CORNERSTONE CHIROPRACTIC** may demand payment immediately.

_____Print Practice Members Name

_____Practice Member Signature

_____Date

Acknowledged by Attorney this_____day of _____, 20___

_____ Attorney Signature

CORNERSTONE CHIROPRACTIC

Automobile/PI Accident or Work Comp Questionnaire

Patient's Name **Date of Birth** **HR#:**

Dear Patient:
This information is considered confidential. Your answers will help us determine if chiropractic care can help your condition. We will not accept your case if we do not believe your condition will respond satisfactorily to care. In order for us to understand your condition properly, please be as neat and accurate as possible while completing this form.
Thank you.

Please answer all questions completely.

Please explain in detail how your accident happened: _____

_____

_____

What were the time and date of present injury? _____

Where did you feel pain immediately after the accident? _____

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

_____

_____

Did you require post-accident hospitalization? □ Yes □ No

Check symptoms you have noticed since the accident:

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

Symptoms other than above: _____

_____

Where were you taken after the accident? _____

Hospitalized? □ Yes □ No If yes, admitted? _____ How long? _____

Name of Hospital: _____

Name of Doctor(s): _____

What treatment was given? _____

Patient's Name **Date of Birth** **HR#:**

Was any other doctor consulted after your accident? □ Yes □ No

If so, what was the doctor's name? _____ D.C., M.D., D.O., D.D.S.

What was the diagnosis? _____

What treatment was given? _____

How often did you see the doctor? _____

How long did you see the doctor? _____

Have you ever had any complaints in the involved area before? □ Yes □ No

If so, what were the complaints? _____

Before the injury were you capable of working on an equal basis with others your age? □ Yes □ No

Are your work activities restricted as a result of this accident? □ Yes □ No

Since this injury are your symptoms ... □ Improving? □ Getting worse? □ Same?

Driver of other vehicle (if any):

Name _____ Insurance Company _____ Policy No. _____

Driver of vehicle in which you were injured (if applicable):

Name _____ Insurance Company _____ Policy No. _____

Name of your insurance adjustor _____

Have you retained an attorney? □ Yes □ No

If so, his/her name and address_____

You were heading North/ East/ South/ West on _____ (street or highway)

Other vehicle was heading North/ East/ South/ West on _____ (street or highway)

Were police notified? □ Yes □ No

Were you knocked unconscious? □ Yes □ No If yes, for how long? _____

You were struck from Behind/ Front/ Left Side/ Right Side _____

You were Driver/ Passenger/ Front seat/ Back Seat/ Using seat belts _____

Patient Signature _____ Date _____

Doctor Signature _____ Date _____