Fogarty
Chiropractic Life Clinic

LASTING PURPOSE

Kevin Fogarty, D.C., F.I.C.A. (Hon)

Automobile Accident History Form

Your Name: _____ Today's Date_____

Date of Accident:_____ Time of Accident: _____ A.M. / P.M.

Street of Accident_____ Heading N / S / E / W

City of Accident:_____

Road Conditions at time of accident: WET / DRY/ ICY/ OTHER_____

List the year, make and model of the car you were in:
Year:_____Make:_____Model:_____
Was the vehicle you were in stopped at the time of the impact? YES / NO
If yes, was the driver's foot on the brake? YES / NO
If no, then estimate the speed of the vehicle you were in: _____mph

List the year, make and model of the other vehicle:
Year:_____ Make: _____ Model:_____

Was the other vehicle moving at the time of the collision? YES / NO
If yes, what was the approximate speed?_____mph

If the other vehicle was moving at the time of the collision, was it:

SLOWING DOWN

SPEEDING UP

TRAVELING AT A STEADY RATE OF SPEED

Which of the following vehicle parts were broken during the accident? _____

_____

What was the estimated cost damage to the vehicle you were in? $ _____

Please describe, to the best of your knowledge what happened during the accident:

_____

_____

_____

_____

_____

_____

_____

(please turn over)

Where were you seated in the vehicle?_____

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Were you aware of the impending collision prior to the impact, or did the impact surprise you? AWARE / SURPRISED

Was the trunk of your body pointed straight forward? YES/ NO
If no, in what direction was it turned?_____

Was your head pointed straight forward? YES / NO
If no, in what direction was it turned?_____

How far is the top of the headrest or seatback from the top of your head (approximately):
_____ inches ABOVE / BELOW.

Were you wearing a seatbelt? YES / NO
If yes, was it a LAPBELT ONLY or SHOULDER AND LAPBELT?
Did the police come to the accident scene? YES / NO; Is there a report? YES / NO
Did you go to the hospital? YES / NO, If yes:
What is the name of the hospital?_____
How did you get there?_____
What parts of your body were X-rayed?_____
What did the hospital do for your injuries?_____
How long did you stay at the hospital?_____
Were there any bleeding cuts sustained in the accident?_____
Were there any bruises sustained in the accident?_____
Did you receive any injury or bruising from your seatbelt? YES / NO
Did you lose consciousness (blackout) upon impact?_____
Did you experience a flash of light or explosion in your head? YES / NO
On what part of the vehicle did your body parts hit?_____

WINDSHIELD FRONTSEAT RIGHT/LEFT SIDE WINDOW

STEERINGWHEEL OTHER_____

Did you become?

CONFUSED DISORIENTED LIGHTHEADED

DIZZY NAUSEATED BLURRED VISION

RINGING/BUZZING IN THE EARS

Immediately following the accident, if you still have any of these symptoms which are they?_____

Are you currently suffering from any of the following ?

RESTLESSNESS, DIFFICULTY CONCENTRATING, SLEEPLESSNESS, IRRITABILITY, DIFFICULTY WITH MEMORY, FORGETFULNESSS , REDUCED TOLERANCE TO COLD, REDUCED TOLERANCE TO HEAT OR REDUCED TOLERANCE TO ALCOHOL.

Rev. June 25, 2013

APPLICATION FOR FLORIDA "NO FAULT" BENEFITS

NAME OF INSURANCE COMPANY

DATE	OUR POLICY HOLDER	DATE OF ACCIDENT	FILE NUMBER

TO ENABLE US TO DETERMINE IF YOU ARE ENTITLED TO BENEFITS UNDER THE FLORIDA PERSONAL INJURY PROTECTION LAW, PLEASE COMPLETE THIS FORM AND RETURN IT PROMPTLY.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD OR DECEIVE ANY INSURANCE COMPANY MAKES A STATEMENT OF CLAIM CONTAINING ANY FALSE INCOMPLETE OR MISLEADING INFORMATION, IS GUILTY OF A FELONY OF THE THIRD DEGREE.

YOUR NAME	PHONE NO.	HOME	BUSINESS

YOUR ADDRESS (NO, STREET, CITY OR TOWN, STATE AND ZIP CODE)	DATE OF BIRTH	SOCIAL SECURITY NO.

PERMANENT ADDRESS, IF DIFFERENT	HOW LONG HAVE YOU LIVED IN FLORIDA?

DATE AND TIME OF ACCIDENT	PLACE OF ACCIDENT (STREET, CITY OR TOWN AND STATE)

BRIEF DESCRIPTION OF ACCIDENT AND VEHICLES INVOLVED:

DESCRIBE MOTOR VEHICLE YOU OWN -	DESCRIBE MOTOR VEHICLE OWNED BY ANY MEMBER OF YOUR FAMILY-

AS A RESULT OF THIS ACCIDENT, WERE YOU INJURED? IF YOUR ANSWER IS YES, COMPLETE THE REST OF THIS FORM. IF NO, SIGN HERE AND RETURN THIS FORM TO US.

SIGNATURE: **DATE:**

DESCRIBE YOUR INJURY

WERE YOU TREATED BY A DOCTOR?	Yes	DOCTOR'S NAME AND ADDRESS Dr. Kevin Fogarty, D.C. - Fogarty Chiropractic Life Clinic - 839 Barton Blvd., Rockledge, FL 32955
IF YOU WERE TREATED IN A HOSPITAL, WERE YOU AN IN PATIENT ____ OUT PATIENT ____		HOSPITAL'S NAME AND ADDRESS

AMOUNT OF MEDICAL BILLS TO DATE	WILL YOU HAVE MORE MEDICAL EXPENSE?	AT THE TIME OF YOUR ACCIDENT, WERE YOU IN THE COURSE OF YOUR EMPLOYMENT?

DID YOU LOSE WAGES OR SALARY AS A RESULT OF YOUR INJURY?	IF YES, AMOUNT OF LOSS TO DATE WHAT IS YOUR AVERAGE WEEKLY WAGE OR SALARY?

IF YOU LOST WAGES:	DATE DISABILITY FROM WORK BEGAN	DATE YOU RETURNED TO WORK

HAVE YOU RECEIVED, OR ARE YOU ELIGIBLE FOR, PAYMENTS UNDER ANY WORKMEN'S COMPENSATION OR EMPLOYMENT LAW?	IF YES, AMOUNT PER WEEK PER MONTH

LIST NAMES AND ADDRESSES OF YOUR PRESENT EMPLOYER(S) AND GIVE YOUR OCCUPATION AND DATES OF EMPLOYMENT FOR EACH

EMPLOYER AND ADDRESS	YOUR OCCUPATION	FROM	TO
EMPLOYER AND ADDRESS	YOUR OCCUPATION	FROM	TO
EMPLOYER AND ADDRESS	YOUR OCCUPATION	FROM	TO

AS A RESULT OF YOUR INJURY HAVE YOU HAD ANY OTHER EXPENSES?	IF YES, EXPLAIN ON REVERSE SIDE
SIGNATURE: DATE:	

IMPORTANT: 1. TO BE ELIGIBLE FOR BENEFITS COMPLETE AND SIGN THIS APPLICATION
2. SIGN AND ATTACH AUTHORIZATION(S)
3. RETURN PROMPTLY WITH ANY MEDICAL BILLS YOU HAVE RECEIVED TO DATE