Patrick A. Tribble, D.C.

912 The Alameda
Berkeley, CA 94707
Doctor of Chiropractic
(510) 525-4825

Personal Injury/ Automobile Accident History

Date _____

Last Name_____ First Name_____ Middle Initial ___ Birth Date_____

Address_____ City_____ State_____ Zip_____

Phone (Primary) _____ Phone (Secondary) _____

Email Address _____

Emergency Contact _____ Phone_____ Relationship _____

Date of Accident _____ Time of Accident _____am/pm Daylight Dawn Dusk Dark

Was the accident on the job? Yes No Were you in a company vehicle? Yes No

Where were you seated in the vehicle? Driver Passenger Rear-seat Other: _____

Were you aware of the approaching collision prior to impact or did it catch you by surprise? Aware/Surprise

Did you lose consciousness upon impact? Yes No

Did you experience a flash of light or explosion in your head? Yes No

Did the police come to the accident scene? Yes No Is there a Police Report? Yes No

Did you go to the hospital? Yes No When? Immediately ___Hours Later

Hospital Name _____ Name of Physician _____

How long did you stay in the hospital? _____ What did the hospital do for your injuries? _____

_____

Were X-rays or MRI's taken? Yes No What X-Rays or MRI's were taken? _____

Was any other doctor consulted after your accident? Yes No Physician Name _____

Were you wearing a seatbelt? Yes No If yes, did you receive any injury from seat belt? Yes No

Did you hit the head rest during the accident? Yes No

If adjustable, was the position of the head rest altered? Yes No

Did the air-bag deploy? Yes No If yes, did it strike you? Yes No Where? _____

Where were your hands? On the wheel Both on the wheel No Applicable

Patient Name: _____ Date: _____

Your Car

List the year, make and model: YEAR_____ Make _____ MODEL _____

Was your car stopped at the time of impact? Yes No If yes, was the driver's foot on the break? Yes No

If no, estimate the speed the vehicle you were in: _____MPH

If your vehicle was moving at the time of impact, was it: Slowing down Gaining Speed Steady Speed

Other car

List the year, make and model: YEAR_____ Make _____ MODEL _____

Was the other car moving at the time of impact? Yes No

If yes, estimate the speed of the vehicle: _____MPH

At the time of the impact was the other car: Slowing down Gaining Speed Steady Speed

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

_____

_____

_____

_____

_____

You may draw the accident here:

Automobile Insurance Information

Driver of automobile you were in: _____ Name of their insurance: _____

Policy #: _____ Claim #: _____

Auto Insurance Phone: _____ Adjuster Name: _____

Other Car Automobile Insurance Information

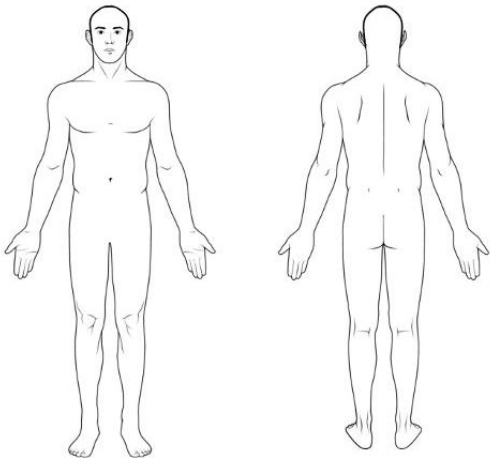
Driver of other automobile: _____ Name of their insurance: _____

Policy #: _____ Claim #: _____

Auto Insurance Phone: _____ Adjuster Name: _____

Please mark off all of areas of complaint on the diagrams with the following indicators:

A = Ache
D = Dull
N= Numbness
B = Burning
T = Tingling
S = Sharp/Stabbing
X = Other



Please list any medication or vitamins you are currently taking (including dosage).

_____

_____

_____

_____

_____

Please rate the intensity of your symptoms on a scale of 0-10 (0 being no symptoms, 10 being extreme).

0 . . . . 1 . . . . 2 . . . . 3 . . . . 4 . . . . 5 . . . . 6 . . . . 7 . . . . 8 . . . . 9 10

Do you smoke?	Yes	No	Have you ever smoked in the past?	Yes	No
Do you consume alcohol?	Yes	No	Do you consume caffeine?	Yes	No
Do you exercise?	Yes	No	Do you have a high stress level?	Yes	No

At the time of the accident, did you become or experience any of the following:

__ Confused __ Disoriented __ Light Headed __ Dizzy __ Nauseated __Blurred Vision __ Ringing/Buzzing in Ears __ Loss of Balance

Is there any possibility that you may be pregnant? Yes No Date of last menstrual Cycle: _____

Please check if you have any of the following:

☐ Headaches/Migraines	☐ Neck Pain	☐ Upper Back Pain	☐ Shoulder Pain	☐ Mid back Pain
☐ Low Back Pain	☐ Arthritis	☐ Disc Degeneration	☐ Arm/Leg Pain	☐ Jaw Pain/Clicking
☐ Dizziness	☐ Fatigue	☐ Fibromyalgia	☐ Asthma	☐ Numbness/Tingling
☐ Allergies	☐ High Cholesterol	☐ Digestive Problems	☐ Joint Pain/ Stiffness	☐ Menstrual Problems
☐ Pinched Nerve	☐ Loss of Sleep	☐ Glaucoma	☐ Diabetes	☐ High Blood Pressure
☐ Cancer	☐ Nervousness	☐ AIDS/HIV	☐ Osteoporosis	☐ Heart Disease/Issue
☐ Paralysis	☐ Parkinson's Disease	☐ Kidney Disease	☐ PMS/Cramps	☐ Prostate Problems
☐ Rheumatoid Arthritis	☐ Sciatica	☐ Sinus Pain	☐ Pacemaker	☐ Stroke
☐ Thyroid Problems	☐ Tumors/Growths	☐ Urinary Problems	☐ Vascular Disease	☐ Vision Problems
☐ Other: _____				

I understand and agree that health insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Patrick Tribble, D.C. will prepare any necessary reports and forms to assist me in making collection from the insurance company. I authorize payment of insurance benefits directly to Patrick Tribble, D.C. I also authorize the doctor to release all information necessary to communicate with personal physicians, other healthcare providers, and/or payers to secure the payment of benefits. However, I clearly understand I am personally responsible for all costs of treatment rendered, regardless of insurance coverage. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered will be immediately due and payable.

Patients Name Print: _____

Patient's Signature:_____ **Date** _____

Patrick A. Tribble, D. C.

Financial Agreement - Personal Injury/ Automobile Accident

We would like to take this opportunity to welcome you to the office and assure you that you will receive the very best care available for your injury. In order to familiarize you with the financial policy of our office, we would like to explain how your medical bills will be handled.

Responsibility for Payment: If you have Med-Pay benefits available on your automobile insurance policy, we will bill your insurance and accept those benefits for payment. If at any point your Med-Pay benefits become exhausted, you will be responsible for paying for your care at the time of service.
If you do not have Med-Pay benefits, than you will be responsible for paying for each of your visits and at the end of your treatment we will provide documentation and your payment ledger for you to seek reimbursement through another source.

Cancellation and No-show Policy: Appointments you schedule are reserved especially for you. If you need to reschedule or cancel an appointment, we request and appreciate a minimum of 24-hours notice. For the best customer service, we ask that you make schedule changes during our normal business hours.

Appointments cancelled with less than 24 hours notice will be assessed a fee as follows: $45 for chiropractic office visits; this is something that insurance will not cover or pay for.

We hope this has answered any questions that you might have about our financial agreement. If at any time you have further questions regarding your financial agreement, please do not hesitate to ask us.

I have read, understand and agree to the above financial agreement for Patrick A. Tribble, D.C.

_____ _____

Patient's Signature Date

_____

Patient's Name