Dr . W. Charlton (705) 646-8887
Chiropractor/Acupuncturist

Parkwood Chiropractic Centre
166 Manitoba Street
Bracebridge, Ontario
P1L 2E2

MOTOR VEHICLE INSURANCE INFORMATION

PATIENT NAME: _____

INSURANCE COMPANY: _____

STREET: _____ UNIT#_____

CITY: _____ PROV._____ POSTAL CODE: _____

CLAIMS ADJUSTER: _____ PHONE: (___) - _____

POLICY #: _____ CLAIM #: _____

DATE OF ACCIDENT: _____

EXTENDED HEALTH COVERAGE

CHIROPRACTIC COVERAGE: YES NO

IF YES: TOTAL ALLOWED $_____ , DEDUCTIBLE $_____

INSURANCE COMPANY: _____

STREET: _____ UNIT#_____

CITY: _____ PROV._____ POSTAL CODE: _____

PHONE:(___) - _____

POLICY #: _____ GROUP #: _____

EMPLOYER: _____

STREET: _____ UNIT#_____

CITY: _____ PROV._____ POSTAL CODE: _____

PHONE:(___) - _____

AUTHORIZATIONS

I _____ hereby authorize Dr. W. Charlton to furnish to the above stated insurance company(s), all information directly related to my medical condition and treatment received as a consequence of the above stated automobile accident.

I _____ hereby authorize the above stated insurance company(s) under their respective policy/claim numbers to pay by cheque made out and mailed directly to Parkwood Chiropractic Centre, the medical expense benefits allowable and otherwise payable to me under my current insurance policy(s), as payments toward the total charges for Professional Services Rendered. This payment will not exceed my indebtedness to the above mentioned assignee and I have agreed to pay, in a current manner, any balance of said Professional Service charges over and above this insurance payment.

Patient signature _____ Date _____ 20_____
Address _____

_____

_____

2 pieces of Photo ID required
(Driver's license and Health Card)

Motor Vehicle Accident Form

Patient's Name_____

Attorney's Name & Telephone # (if any)_____

1.a.Date of accident_____Time _____ a.m. / p.m.
b.Where did accident occur? Street_____
Direction of travel_____

2.a.Were you driving?_____
b.Number of passengers?_____
c.Model of your vehicle?_____
d.At time of accident was your car..... stopped___ moving___ turning___ R/L
e.State exactly where your car was struck... front___ rear___ driver's side___ passenger's side___
f.Model of vehicle which struck you? _____
g.Estimate of damage to vehicles _____

3.a.Did you see the accident coming?_____
b.Were seatbelt worn? _____
c.Upon impact, which direction were you thrown? _____
d.Upon impact was there a *blinding* or *explosion* sensation in your head? _____
e.Which areas of your body hurt immediately after the accident?
_____
f.Were you able to get out of the car and walk? _____
g.Were you conscious at all times during and immediately after the accident?_____
h.Could you move all parts of your body? _____
i.Was your headrest up or down? _____

4.a.Was an ambulance called for you?_____
b.Did you go to the hospital? _____
c.If so, what was done? Examination_____ X-rays_____ Medication_____
d.How long were you in the hospital? _____
e.Name of hospital _____
f.Have you seen any other doctors for this injury? _____
If so, name and telephone # of doctor_____

5.a.What discomfort did you have the first evening? _____
_____
b.Were you able to sleep the first night following the accident? _____
c.What discomfort did you have the next day? _____
_____

6.a.Was a police report made?_____ Were charges laid?_____
Against whom?_____

7.a.Check off any of the following symptoms you have had since the accident.
Complaints of: eyes___ ears___ face___ dizziness___ sweating___
difficulty swallowing___ nasal disturbances___ chest disturbances___
unconsciousness___ headaches___ insomnia___ restlessness___
mood changes___
Symptoms of arms and legs: numbness___ tingling___ difficulty in moving___
loss of strength___ inability to void___
total period of disability_____
8.Comments:_____
_____