Mark Eiler, D.C. ; Justin Eiler, D.C. ; Andrea Eiler, D.C.

Oakview Medical Building Suite 230

AUTO RELATED ACCIDENT

Patient Auto Insurance: ____

Claim Number: ____

Mailing address for claims: ____

____

Phone Number: ____

Agent Name: ____

Person at Fault Auto Insurance: _____________________________________

Person at Fault Name: ____

Claim Number: ____

Mailing address for claims: ____

____

Phone Number: ____

Agent Name: ____

2727 South 144th Street Suite 230
Omaha, Nebraska 68144
Phone: (402) 778-5470
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Auto Related Accident

Name: ____ Date: _________________________

Date & Time of Accident: ____ ( )am ( )pm
Were you the: ( )Driver ( )Front passenger ( )Rear passenger
If a traffic violation was issued, to whom was it issued? ____________________________

Number of people in accident vehicle? _____________
Did the police come to the accident site? ( )Yes ( )No
Was a police report filed? ( )Yes ( )No
Were there any witnesses? ( )Yes ( )No
Were you wearing your seat belt? ( )Yes ( )No
Was this vehicle equipped with airbags? ( )Yes ( )No
If yes, did it/they inflate?
In relation to the base of your skull, where was the headrest?
( )Above ( )Below ( )At base of skull
What did your vehicle impact? ( )Another vehicle ( )Other
If other, please explain:____
Did any part of your body strike anything in the vehicle? ( )Yes ( )No
If yes, please explain: ____

Make & Model of the vehicle you were occupying: ________________________________
Name of the location/street on which you were traveling: __________________________
____
In which direction where you headed? ( )N ( )S ( )E ( )W
What was the approximate speed of your vehicle? ___________________
Did the impact to your vehicle come from:
( )Front ( )Rear ( )Right side ( )Left side ( )Other
During impact, were you facing? ( )Right ( )Left ( )Forward
Were you ( )aware or ( )surprised by the impact?

Make & Model of the other vehicle: ______________________________

Direction other vehicle was headed? ( )N ( )S ( )E ( )W

Did accident render you unconscious? ( )Yes ( )No

If yes, for how long? ______________________________

Please describe how you felt immediately after the accident? ______________________________

____

Have you seen another health care provider since the accident? ______________

If yes, please list name and phone number: ______________________________

____

When did you go? ( )Just after the accident ( )The next day ( )2 days plus

How did you get there? ( )Ambulance or ( )Private transportation

Please describe the treatment you received: ______________________________

____

Were x-rays taken?

Was medication prescribed?

Have you been able to return to work?

Are your work activities restricted?

Indicate the symptoms that are a result of this accident:

( )Dizziness ( )Difficulty sleeping ( )Jaw problems ( )Nausea

( )Memory loss ( )Arm/Shoulder pain ( )Irritability ( )Back pain

( )Headaches ( )Lower back pain ( )Numb hands ( )Fatigue

( )Tension ( )Blurred Vision ( )Chest pain ( )Back stiffness

( )Neck pain ( )Shortness of breath ( )Leg pain ( )Buzzing in ear

( )Ears ringing ( )Numb feet/toes ( )Stiff neck ( )Stomach upset

( )Other: ______________________________

Is your condition getting worse? ( )Yes ( )No ( )Comes & goes

Have you retained an attorney: ( )Yes ( )No

If yes, whom: ______________________________

____

Phone # ( ) ______________________________

I understand the above information and guarantee this form was completed correctly to the best of my knowledge. I fully understand I am solely responsible for any balance not paid for by my insurance company.

Signature:______________________________ Date: ______________________________