Personal Injury/ Slip and fall Accident / Workers Compensation Accident

Date of accident ______/________/_________ **Time Accident occurred :**____:____ AM/PM

Location of Accident: ____

Has the injury/accident been reported? Yes No Reported To:_____________________

Have you been treated or seen at any other medical facility for injuries sustained in the accident?
Yes No

Clinic/ Hospital:_____________________________

Number of Visits:_____________________________

Brief Description of Accident:

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____

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Claim Number:____

Insurance Company:____

Attorney:____

Signature_______________________________________ Date____/_____/_______

Personal Injury Accident

Were you the: Driver, front seat passenger, rear seat passenger right/left/ middle, car seat

Airbags Deployed? Yes No

Did you lose consciousness due to accident? Yes No

In what direction were you looking: Straight, down, left, right, over shoulder right/left

Your Vehicle Impact: Left, Right, Front, Rear, Side, Head-on, Unknown

Your Vehicle Movement: Stopped, Backing up, Movement Unknown, Moving Forward, Turning left/right

Your Speed at time off accident:____________

Damage to your vehicle: No visible damage, Slight damage, Moderate damage, Heavy damage, Totaled

Other Vehicle Impact: Left, Right, Front, Rear, Side, Head-on, Unknown

Other Vehicle Movement: Stopped, Backing up, Movement Unknown, Moving Forward, Turning left/right

Other vehicle Speed at time of accident:________

Was Your vehicle towed from the scene? Yes No

Was an ambulance called to the scene: Yes No

Were you transported by ambulance after the accident: Yes No

Were the police at the scene? Yes No

Was there a citation issued? Yes No **To who**:____________________

Was an accident report filled out: Yes No

Did you strike any part of your body: Yes No **(if yes please describe what body part and what you came in contact with)** ____

What pain was felt at the time of the accident: Dull Ache, Sharp/Stabbing, Numbness, Burning, Tingling, Tightness, Other

Since the accident pain has got : Better, Worse, Much Worse, Stayed the same

Signature:______________________________________ Date:___/_____/________

SPRINGFIELD
FAMILY CHIROPRACTIC LLC

281 State St. Ste 1F Springfield, MA 01103.
P: 413 335 2558 F: 866 711 9657 Email: dr.pauldion@gmail.com

Lien/Waiver

I,______________________________________ was injured on _______________ and have received treatment for my injuries by Dr. Paul J. Dion, of Springfield Family Chiropractic LLC. Located at 281 State St. Ste 1F Springfield Massachusetts 01103. I am currently represented by counsel in relation to these injuries and am seeking recovery for these injuries from a third party.

I hereby direct my attorney to communicate with Dr. Paul J. Dion and/or his staff regarding the progress/ status of my case. Furthermore, I direct my attorney to pay directly out of my settlement, judgment, or any funds received as a consequence of my injuries. All injuries related expenses incurred by me with Dr. Paul J. Dion for his care and treatment of my injuries.

I acknowledge that treatment is ongoing and updated liens are to follow as my care progresses through the treatment plan as explained to me during the initial examination and review of findings performed by Dr. Paul J. Dion on the below signed date.

I have received a copy of this lien/waiver. A photocopy of this lien shall have the same force and effect as the original and will be forwarded to my attorney and/or the involved insurance company.

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Patient Signature Date: