Patient Information- Accident/ Injury Form

Name_____ Date_____

Date of Accident_____ Time: ___am ___pm Location_____

Auto Accident

Were you: ( )Driver ( )Passenger ( )Pedestrian
Were you struck from: ( )Behind ( )Right ( )Left ( )Head-on
Approximate Speed of vechiles: ____(mph) you ____(mph) other party
Were you wearing seat belt: ( )Yes ( )No
As a result of the accident were traffic citations issued: ( )Yes ( )No
If yes, to whom_____

On-the-Job Injury

How did the injury occur?

_____

_____

Did you report the injury to management? ( )Yes ( )No
Employer_____ Address_____

Other

Describe the circumstances of the accident (Be specific as possible)

_____

_____

Check symptoms noticed since the accident

( )Neck pain	( )Headache	( )Numbness in arms/hands
( )Dizziness	( )Loss of memory	( )Loss of Taste
( )Ears Ringing	( )Light sensitivity	( )Loss of Smell
( )Back pain	( )Pain in legs/feet	( )Numbness in legs/feet

Did you require post-accident hospitalization? ( )Yes ( )No
Have you lost any days of work? ( )Yes ( )No If yes, _____to_____

Insurance Information

Your Insurance Company_____ Address_____
Other Parties Name_____ Address_____
Other Parties Ins. Co._____ Address_____

Has an insurance adjuster regarding this claim contacted you? ( )Yes ( )No
If yes, Name of Adjuster_____ Company_____

Do you have an attorney that has advised you in this case? ( )Yes ( )No
If yes, Attorney's Name_____ Address_____

Signature_____ **Date**_____

Doctor's Lien

To:_____
_____
_____

Dr. Mike Kenkel
407 Sharp St.
Glenwood, IA 51534
712 527-5800

RE: Medical Reports and Doctor's Lien

I do hereby authorize the above doctor to furnish you with a report of his examination, diagnosis, treatment, prognosis, etc., of myself in regard to the accident in which I was involved.

I hereby authorize and direct you to pay directly to said doctor such sums as may be due and owing him for medical services rendered me both by reason of this accident and by reason of any other bills that are due to his office and to withhold such sums from settlement, judgement, or verdict which may be paid to you or myself as the result of the injuries for which I have been treated or injuries in connection herewith.

I fully understand that I am directly and fully responsible to said doctor for all medical bill submitted by her for service rendered to me and that this agreement is made solely for said doctor's additional protection in consideration of him awaiting payment. And I further understand that such payment is not contingent on any settlement, judgement, or verdict by which I may eventually recover said fee.

Dated:_____ Patient Signature:_____

The undersigned does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgement, or verdict as may be necessary to adequately protect said doctor above named.

This lien does not constitute a request or agreement between the parties for the attorney or law firm to act as a collection agency for the above-named doctor.

Dated:_____ Signature:_____