

# ACCIDENT INFORMATION

## Accident Details

Date and time of accident: \_\_\_/\_\_\_/\_\_\_ Time: \_\_\_:\_\_\_ AM/PM Home / Work / Motor Vehicle Crash / Other

State in which accident occurred: \_\_\_\_\_

How did the accident happen? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

## Automobile Accidents

Were you? Driver / Passenger / Pedestrian

If Passenger, where were you seated: \_\_\_\_\_

What kind of vehicle were you in? \_\_\_\_\_

Did your vehicle strike another vehicle? Yes / No

Did another vehicle strike the vehicle you were in? Yes / No

If hit by another vehicle, what size and type of vehicle was it? \_\_\_\_\_

Did your vehicle leave the pavement? Yes / No Did your vehicle go into a ditch? Yes / No

Did your vehicle hit anything else? Yes / No If so, what? \_\_\_\_\_

How fast were you going? \_\_\_\_\_ mph

Where was your vehicle hit? \_\_\_\_\_

Amount of damage? Slight / Moderate / Extensive / Totaled

Was there any damage inside your vehicle? Yes / No What was damaged? \_\_\_\_\_

Was your vehicle able to be driven from the accident? Yes / No

Was your vehicle removed by a wrecker? Yes / No

Do you have any pictures of the involved vehicle? Yes / No

Were you wearing a seat belt? Yes / No Shoulder harness? Yes / No

Did the airbags deploy? Yes / No

Did you hit any part of your body during the crash (eg. head on steering wheel, knees on dash)? Yes / No

If yes, which part and where? \_\_\_\_\_

\_\_\_\_\_

# ALL ACCIDENTS

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Immediately following the accident, how did you feel? \_\_\_\_\_

Were you knocked unconscious? Yes / No      If yes, how long? \_\_\_\_\_

Were you in a daze? Yes / No      Did you go to the hospital? Yes / No

Were you able to exit the vehicle without assistance? Yes / No

When did you go to the hospital? Same day / Next day / Other: \_\_\_\_\_

If yes, were x-rays taken? Yes / No      Results: \_\_\_\_\_

Were other tests performed? Yes / No      What were the results? \_\_\_\_\_

How were you transported to the hospital? Ambulance / Private Transportation

If transported by ambulance, did they place you in a neck collar? \_\_\_ In splints? \_\_\_ In a brace? \_\_\_

Name of the hospital: \_\_\_\_\_ Name of the doctor: \_\_\_\_\_

What treatment was rendered? \_\_\_\_\_

How long did you stay? \_\_\_\_\_

What follow-up recommendations were made up a new release? \_\_\_\_\_

Have you seen any other doctors as a result of this accident? Yes / No

If yes, who? \_\_\_\_\_ Recommendations/Treatment received: \_\_\_\_\_

What were the results of treatment? \_\_\_\_\_

If work accident, to whom did you report the accident? Name: \_\_\_\_\_ Title: \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_

NOTES:

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## **Assignment, Authorization, and Doctor's Lien**

Doctor: Matthew W. Ryan, DC  
206 East May Street  
Winder, GA 30680

I do hereby authorize the above doctor to release any information and records regarding my treatment or pertinent to my case to all payers, including any insurance company and my attorney, in regard to the accident in which I was involved. In the event that I have medical payments on my insurance, or on anyone's insurance involved with the accident, I authorize the doctor to bill this insurance, and to release all information and medical records to the insurance company to process the claim.

I hereby authorize and direct payment directly to Matthew W. Ryan, DC such sums as may be due and owing him for services rendered me both by reason of this accident and by reason of any other bills that are due his office and to withhold such sums from settlement, judgment, or verdict as may be necessary to adequately protect said doctor. I hereby further give a lien on my case to said doctor against any and all proceeds of any settlement, judgment, 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.

In the event that I retain one or more attorneys, I will request that each attorney protect Matthew W. Ryan, DC ensuring payment of my charges out of any proceeds received by my attorney(s) relating to my accident directly to Matthew W. Ryan, DC.

I fully understand that I am directly and fully responsible to said doctor for all bills submitted by him for service rendered to me and that this agreement is made solely for said doctor's additional protection and in consideration of his awaiting payment. And I further understand that such payment is not contingent on any settlement, judgment, or verdict by which I may eventually recover said fee. This lien does not constitute any consideration for the doctor to await payments and he may demand payments from me at the time of service. If the doctor must take action to collect an outstanding balance on my account, I will be responsible for payment and will reimburse the doctor for all cost of such collections efforts, including, but not limited to, all court cost and all attorney fees.

This Assignment shall not be modified or revoked without the mutual written consent of Matthew W. Ryan, DC and myself. I hereby revoke any previously signed authorizations, whether executed at this office or any other office to the extent that the terms of those authorizations conflict with the terms of this Assignment.

Dated: \_\_\_\_\_

Patient's Signature: \_\_\_\_\_

Dated: \_\_\_\_\_

Doctor's Signature: \_\_\_\_\_