MICHIGAN HEAD & NECK INSTITUTE - *ACCIDENT/INJURY – ADDENDUM*

PATIENT INFORMATION

Last Name: _____ First Name: _____ Middle Initial: ____

INSURANCE INFORMATION

Auto Insurance *{Complete only if injury is result of an auto accident}*
Subscriber's Name: _____ Subscriber's D.O.B.: _____
Policyholder SS# _____ Policyholders relationship to patient: _____
Insurance Co: _____ Phone #: _____
Address: _____
City: _____ State: _____ Zip: _____ Has this accident been reported? [ ] Yes [ ] No
Claim No: _____ Date of injury: _____
Adjuster: _____ Adjuster Phone#: _____

Workers Compensation *{Complete only if injury is result of a work related incident}*
Employer: _____ Date of Accident: _____
Address: _____
City: _____ State: _____ Zip: _____
Has this incident been reported? [ ] Yes [ ] No If yes was treatment authorized? [ ] Yes [ ] No
Insurance Co: _____ Phone no: _____
Address: _____
City: _____ State: _____ Zip: _____ Claim No: _____
Adjuster: _____ Phone #: _____

What do you believe is the cause of your pain or condition?

[ ] An automobile accident (Date: _____)
[ ] A motorcycle accident (Date: _____)
[ ] A work-related accident (Date: _____)
[ ] A slip and fall accident (Date: _____)
[ ] Other: _____

What other information is important to your condition? _____
_____

ACCIDENT INFORMATION

Date of accident: _____ Time: _____

[ ] Were you a passenger in a vehicle? [ ] Did you fall? [ ] Were you a pedestrian?
[ ] Were you the driver of a vehicle? [ ] Did an object hit you? [ ] Were you at work?
[ ] Other: _____ [ ] Did you hit an object?

Were any areas of your body painful shortly after the accident/incident?

[ ] Jaw [ ] Head [ ] Left arm [ ] Left shoulder [ ] Lower back
[ ] Face [ ] Neck [ ] Right arm [ ] Right shoulder [ ] Upper back
[ ] Other: _____

Please describe your accident/incident:

_____
_____

Patient Signature: _____ Date: _____

Print Name: _____ Date of Birth: _____

Did you lose consciousness? [ ] Yes [ ] No, If yes, how long? _____
Were you dizzy or confused? [ ] Yes [ ] No
Did you go to the hospital? [ ] Yes [ ] No
If yes, how did you get there? [ ] By car [ ] By ambulance [ ] Other _____
If taken by ambulance did they use [ ] a Backboard, or [ ] Neck brace?
Name of hospital taken to: _____
How long were you hospitalized for? _____

If you have had a previous accident(s) or incident(s) please list the date and a detailed description of your accident(s):

_____

_____

_____

Name(s), address(s), and phone number(s) of hospital and/or doctors where you were treated for this previous accident or incident: _____

_____

_____

If you were in a vehicle, where was the vehicle hit?
[ ] At front end [ ] At rear end [ ] On the driver's side [ ] On passenger's side
[ ] Head on [ ] Other: _____
Were you wearing your seat belt? [ ] Yes [ ] No Was anyone else hurt in the accident? [ ] Yes [ ] No
If yes, please list names of others involved and their relationship to you: _____

_____

Were you cited with a traffic violation? [ ] Yes [ ] No
Was the driver of the vehicle in which you were a passenger cited with a traffic violation? [ ] Yes [ ] No
Was the driver of the other vehicle cited with a traffic violation? [ ] Yes [ ] No

Did you hit your head? [ ] Yes [ ] No If yes, please check the following information.

	Steering wheel	Windshield	Passenger's side window	Driver's side window	Headrest	Seat	Roof	Other
Forehead								
Face								
Chin								
Right side of head								
Left side of head								
Back of head								
Top of head								
Teeth								
Jaw								
Other								

Patient Signature: _____ Date: _____

Print Name: _____ Date of Birth: _____