Auto Questionnaire

Patient Name_____ Today's Date_____/_____/_____

Attorney Name _____Attorney Number_____

Date of Birth _____/_____/_____ Cell Number _____

Your Auto Insurance Carrier _____

Your Policy Number:_____

THERE IS A PHONE NUMBER ON YOUR INSURANCE CARD. CALL AND ASK THE REP FOR THE FOLLOWING QUESTIONS. THIS INFORMATION IS IMPORTANT.

CLAIM NUMBER_____

CLAIMS ADDRESS_____

DATE OF ACCIDENT_____

ADJUSTER NAME_____

ADJUSTER PHONE_____

ASK "WHAT COMPANY HANDLES PRE-CERTIFICATIONS?"

PRE-CERT COMPANY_____

PRE-CERT ADDRESS_____

PRE-CERT FAX_____

ASK "IS AUTO INSURANCE SET AS PRIMARY PAYOR FOR PIP MEDICAL CLAIMS?"

❒ YES, AUTO INSURANCE THE PRIMARY PAYOR FOR AUTO MEDICAL CLAIMS

❒ NO, MY MEDICAL INSURANCE IS THE PRIMARY PAYOR FOR AUTO MEDICAL CLAIMS

ASK "IS THERE A DEDUCTIBLE FOR MY PIP MEDICAL CLAIMS?"

❒ No Deductible ❒ Yes Deductible, Amount of $_____

ASK "IS THERE A CO-PAYMENT/CO-INSURANCE FOR MY MEDICAL CLAIMS?"

Co-pay/Co-insurance Amount of $_____

ASK "ARE THERE ANY POLICY LIMITS?"

❒ No Policy Limits ❒ Yes Policy Limits, Amount of $_____

ASK "CAN YOU EMAIL ME A COPY OF MY AUTO DECLARATIONS PAGE?"

(After the call, you will forward this E-mail to contact@NJnerve.com)

ASK, "CAN I PLEASE HAVE YOUR NAME AND A REFERENCE NUMBER?"

Name_____

Reference #_____

Accident Information

Patient Name_____ Today's Date:_____

Date of accident:_____ How many weeks has it been since the accident:_____

If over two weeks have passed, please explain why there was a delay in getting care with us here today, for example: work schedule, illness, childcare, transportation, pain has worsened, injury exacerbated…

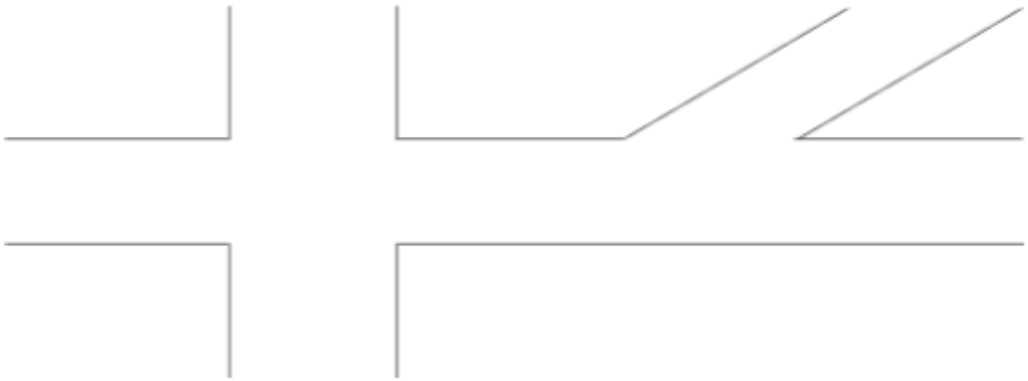
_____

Were you wearing a seatbelt? ❒Yes ❒No ❒Unsure Did the airbags inflate? ❒Yes ❒No ❒Unsure
Did you lose consciousness? ❒Yes ❒No ❒Unsure Did police arrive? ❒Yes ❒No
Did you leave by ambulance? ❒Yes ❒No Did you go to the hospital? ❒Yes ❒No
Have you had x-rays or imaging? ❒Yes ❒No Are you able to work? ❒Yes ❒No
Since accident, you have seen a: ❒Medical Doctor ❒Chiropractor ❒Physical Therapist
I was the ❒Driver ❒Front Passenger ❒Rear Passenger
What direction was your head looking at the moment of impact?

Did your head strike the headrest or anywhere else?

Did a part of your body strike or hit anything?

Impact to your vehicle came from: ❒Front ❒Rear ❒Left Side ❒Right Side
Approximate Speed of Your Vehicle: _____mph Approximate Speed of Other Vehicle: _____mph
Draw out the accident and add any details, symbols, arrows, etc.



Pre-existing issues NOT WORSENED by Accident	**Pre-existing issues WORSENED by Accident**	**New issues From Accident**
List all locations of pain you have had in the past or have now that are unrelated to the accident	List all locations of pains you had issues with before the accident but now are worsened by the accident	List all locations of pains that you have never experienced before and are caused from this accident.