

Accident Addendum

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Accident Information

Name:

Date of Accident:

Time:

Type of Accident (please check one): Auto Workman's Comp Slip & Fall Other

If an Auto Injury, were Police Notified? (If So, Please Provide Office with a Copy of Report)

Please Explain How Your Accident/Injury Occurred:

Did You Feel Pain Immediately After the Injury/Accident, and If So, Where?

List the Extent of Injuries as You Know Them:

Did You Require Post-Accident Hospitalization? If so, Where?

Check All Symptoms You Have Noticed Since the Accident/Injury Occurred:

<input type="checkbox"/> Headaches	<input type="checkbox"/> Depression	<input type="checkbox"/> Neck Pain/Stiffness
<input type="checkbox"/> Light Sensitivity	<input type="checkbox"/> Buzzing/Ringing in Ears	<input type="checkbox"/> Memory Loss
<input type="checkbox"/> Mid Back Pain/Stiffness	<input type="checkbox"/> Low Back Pain/Stiffness	<input type="checkbox"/> Upset Stomach
<input type="checkbox"/> Head Seems Too Heavy	<input type="checkbox"/> Pins/Needles in Arms	<input type="checkbox"/> Pins/Needles in Legs
<input type="checkbox"/> Loss of Balance	<input type="checkbox"/> Loss of Smell	<input type="checkbox"/> Loss of Taste
<input type="checkbox"/> Numbness in Fingers	<input type="checkbox"/> Numbness in Toes	<input type="checkbox"/> Sleeping Problems
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Fatigue	<input type="checkbox"/> Constipation
<input type="checkbox"/> Fainting	<input type="checkbox"/> Shortness of Breath	<input type="checkbox"/> Diarrhea
<input type="checkbox"/> Nervousness	<input type="checkbox"/> Fever	<input type="checkbox"/> Tension
<input type="checkbox"/> Cold Feet	<input type="checkbox"/> Cold Hands	<input type="checkbox"/> Chest Pain
<input type="checkbox"/> Cold Sweats	<input type="checkbox"/> Difficulty Swallowing	<input type="checkbox"/> Blurred Vision
<input type="checkbox"/> Other (please explain):		

List the Names and Phone Numbers of All Doctors Consulted After Injury/Accident:

List the Diagnosis and Treatments Administered:

Driver of Vehicle in Which You Were Injured (if applicable):

Driver's Insurance Company/Policy Number (if applicable):

Name and Phone Number of Attorney (if applicable):

Doctor's Lien

I hereby authorize my doctor to furnish my attorney with a full report of his examination, diagnosis, treatment, prognosis, etc. of myself in regards to the accident in which I was involved.

I hereby authorize and direct my attorney to pay directly to my doctor such sums as may be due and owing him for professional 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 any settlement, judgment, or verdict as may be necessary adequately to protect my doctor. I hereby further give a lien on my case to my doctor against any and all proceeds of any settlement, judgment or verdict which may be paid to my attorney, or myself as the result of the injuries for which I have been treated or injuries in connection therewith.

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

Patient's Signature: _____

Date: _____