INNOVATIVE
SPINE CARE

8333 Gunn Highway Tampa, FL 33626
Phone: 813-920-3022 Fax 813-920-3002
www.GotSpinePain.com

(Please Print Clearly)

Patient Demographics Form

Name _____ Today's Date_____

Address _____

Email _____

Date of Accident _____ DOB _____ SSN _____

Phone # _____ Cell # _____

Sex ☐ M ☐ F Age_____ ☐ Married ☐ Widowed ☐ Single ☐ Divorced/Separated ☐ Minor

Accident Type: Motor Vehicle Slip/Fall Premise Other _____ Date _____

Main Reason for Visit _____

Referred By _____ Referred # _____

Went to ER? Yes No Name ER _____ Date _____

MRI Done? Yes No Where _____ Date _____

X-rays Done? Yes No Where _____ Date _____

MV Ins _____ Claim # _____

MV Ins Address _____

MV Ins Adjustor _____ MV Ins # _____

Status of Case: Pre-Litigation Litigation PIP Exhausted: Yes No

UM Coverage:_____ Policy Limit:_____ BI Coverage:_____Policy Limit:_____

Attorney Name _____

Attorney Address _____

Attorney Phone# _____ Fax# _____Email_____

_____ _____

Signature of patient/Legal Guardian Today's Date

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Patient / Physician Agreement

FAILURE TO FOLLOW PHYSICIAN ORDERS

"Physician Orders" are meant to improve and/or resolve the patient's medical condition and/or symptoms. The patient is expected to follow orders given. In the event the patient does not follow orders given, the patient may be discharged from the treating physician care and/or facility from any injury or illness claim resulting from the patient's failure to follow orders. Not following orders given can include but is not limited to missing, postponing, or refusal of additional tests to rule out, confirm, or discover illness. Also, missing postponing, or refusal of making scheduled appointments can be considered failing to follow physician's orders. I have read, understand, and agree with the above.

Patient/Guardian Signature: _____ Date: _____

PRESCRIPTION REFILLS

Please don't wait until you run out of medicine to call for a refill. In fact, call at least two days ahead. In order to protect you, your doctor must review your medical file before renewing a prescription. Therefore please do not call for medications after hours or on weekends when records are unavailable. It could take up to 48 hours after you call before your doctor can review your file and call in any prescription. The files are reviewed and prescriptions are called to pharmacies at the end of office hours after all patients have been seen. By law, doctors cannot order refills for certain narcotics over the phone. A written prescription is required in those cases. I have read, understand, and agree with the above.

Patient/Guardian Signature: _____ Date: _____

MEDICAL RECORDS

Your records are kept in strict confidence as part of our permanent file. We will release copies only if we have your written permission. We prefer to mail copies of records, but we will give them to you in person to hand-carry if time is critical. Please give us at least 48 hours notice prior to coming in and picking up records as it does take some time to get things together for you. I have read, understand, and agree with the above.

Patient/Guardian Signature: _____ Date: _____

STATEMENT OF FINANCIAL RESPONSIBILITY

I the undersigned realize that all medical and surgical charges incurred by me or my dependent/s are my financial responsibility. All court fees, attorney fees, and other fees necessary to collect this amount are payable by me. I grant consent to Innovative Spine Care to use and disclose my protected health information for the purposes of diagnosing or providing treatment and conducting surgical operations. My protected health information includes demographic information which is collected from me, created or received by my physician or another health care provider, and my employer. This protected information relates to my past, present, and future physical and mental health condition/s. I can receive from Innovative Spine Care a copy of the Notice of Privacy Practices prior to signing this document and understand it is subject to change. I understand that diagnosis and treatment of me by Innovative Spine Care may be conditioned upon my consent as evidenced by my signature on this document. I have read, understand, and agree with the above.

Patient/Guardian Signature: _____ Date: _____

CONFIDENTIALITY

The physician will diagnose your illness according to your complaints, symptoms, test results, and medical history. In order to treat the patient appropriately, the patient understands and authorizes treating physician and/or facility to obtain any and all medical records relating to the patient and to communicate with previous physicians by any method that can assist with the care of the patient. I have read, understand, and agree with the above.

Patient/Guardian Signature: _____ Date: _____

INDIVIDUAL PATIENT AUTHORIZATION

Name the people and/or organization and their relationship to you that are authorizing to use and/or disclose your personal health information:

_____

IRREVOCABLE MEDICAL LIEN

I hereby do authorize any and all parties, including any insurance company and my attorney (if applicable), to pay directly to Innovative Spine Care sums as may be due and owing for medical services rendered to me and to withhold such sums from any settlement, judgment, or verdict as may be necessary to adequately protect Innovative Spine Care. If applicable, I also authorize my attorney to release any and all information without limitation regarding any legal proceedings, judgments, or settlements that will aide in the recovery of Innovative Spine Care's unpaid sum.

I fully understand that I am directly and fully responsible to Innovative Spine Care for all medical bills incurred by me for services rendered in consideration of waiting for payment. I further understand that such payment is not contingent on any settlement, judgment, or verdict by which I may eventually recover said fee.

I hereby further give my authorization to Innovative Spine Care to record a Uniform Commercial Code Form (UCC-1) to protect this medical lien and to send any unpaid sum to the Tortfeaser. I have read, understand, and agree with the above.

Patient/Guardian Signature: _____ Date: _____

I CERTIFY THAT, TO THE BEST OF MY KNOWLEDGE, THE INFORMATION IN THE PATIENT INTAKE FORMS IS ACCURATE.

Patient/Guardian Signature: _____ Date: _____

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Assignment of Benefits (1/2)

Patient: _____ Date of Loss: _____

Insurance Carrier: _____ Claim Number: _____

Policy Owners' Name: _____ Policy Number: _____

For and in consideration of (PATIENT'S NAME): _____ agreeing to pursue the responsible automobile insurance carrier for payment of benefits due and not requiring prepayment of services, I hereby irrevocably assign ALL rights and benefits to INNOVATIVE SPINE CARE for Personal Injury Protection, Medical Payment Coverage, and other benefits which I may have in accordance with Florida statute 627.736. This includes any benefits from my insurance company and any other entity which may be responsible for medical expenses incurred. I further authorize INNOVATIVE SPINE CARE to collect payments& prosecute any necessity actions to collect payment for services as they see fit and allowable by law and contract. THIS DOCUMENT CONSTITUTES AN ABSOLUTE ASSIGNMENT OF RIGHTS AND BENEFITS AS CONTEMPLATED IN PROGRESSIVE AMERICAN INS. CO. V. STAND-UP MRI OF ORLANDO, 990 SO.2D3 (FLA. 5TH DCA 2008).

I hereby further give a lien to INNOVATIVE SPINE CARE against any all insurance benefits named herein, and any and all proceeds of any settlement, judgment or verdict which may be paid to me as a result of injuries or illness for which I have been treated by INNOVATIVE SPINE CARE as a result of the above stated loss date. This document acts as an irrevocable and absolute assignment of all my rights and benefits under all policies of insurance for which I am entitled to coverage thereupon. I agree to cooperate with all employees of INNOVATIVE SPINE CARE and their attorney's (at their choosing), and to do all things reasonable to effect payment of the bills by the insurance company or other entity to INNOVATIVE SPINE CARE including but limited to: disclosing my medical condition, being available for factual discovery, or any other means of cooperation.

INNOVATIVE SPINE CARE hereby objects to any reductions or partial payments. Any partial or reduced payment, regardless of the accompanying language, issued by the insurer and deposited by the provider shall be done so under protest, at the risk of the insurer, and the deposit shall not be deemed a waiver, accord, satisfaction, discharge, settlement, or agreed by the provider to accept a reduced amount as payment in full.

This assignment concerns amounts due INNOVATIVE SPINE CARE and those costs including but limited to: attorney fees, court costs, special report or narrative fees, other costs, and interest necessary to procuring payment from the above-named insurance company and/or other entities. This assignment is not intended to assign any other causes of action that may belong to the undersigned patient. I agree to pay any applicable deductible/s, co-insurance/s, co-payment/s, or any not covered items by any policy of the insurance cited above. I understand that as a benefit and convenience to me, INNOVATIVE SPINE CARE will bill and pursue collection against the insurance company or other responsible party on my behalf. I hereby instruct and direct my insurance company to pay benefits directly to INNOVATIVE SPINE CARE at the address provided on the bill.

Assignment of Benefits (2/2)

INNOVATIVE SPINE CARE's medical care is being provided for a reasonable fee for treatment causally related to the above loss date and is medically necessary. I instruct my insurance carrier or other responsible entity to pay these bills to the full extent of my available benefits under the insurance policy and Florida law. I hereby give INNOVATIVE SPINE CARE limited Power of Attorney to endorse and sign my name on any draft for payment to INNOVATIVE SPINE CARE.

This agreement is intended to serve as an absolute assignment of rights and benefits under my policy of insurance in favor of INNOVATIVE SPINE CARE. If any language within this agreement has the effect of invalidating this agreement, that language shall be deemed void and the remainder of the assignment shall maintain full force and effect. A photocopy of this agreement shall be considered as effective and valid as the original.

As INNOVATIVE SPINE CARE stands in my shoes by virtue of this assignment, the following constitutes rights now owned by INNOVATIVE SPINE CARE, as I have directed herein, and INNOVATIVE SPINE CARE hereby demands, including but limited to:

A. Providing a copy of any applicable insurance policy, declaration page, all applicable endorsements.
B. Transcripts and/or copies or recorded statements, examinations under oath, affidavits of the claimant, affidavits of any provider who treated me, or other sworn statements pursuant to Addison v. Geico General Ins. Co., 17 Fla. L. Weekly Supp. 272a (Hills. Cty. Ct. 2010).
C. Copies of independent or compulsory evaluation, including peer reports or other reports pursuant to 627.736(7) of me.
D. Any police or accident report my insurance company may have for the above listed date of loss
E. A listing of all PIP benefits paid to date on my behalf of AND to me which shall include claims were received, the amount of the claim before reductions or repricing, payment amount or denial of each claim, the amount of the deductible and the claims applied thereto, and whether benefits have been exhausted and the amount of PIP benefits available, commonly known as a "PIP LOG" or "PIP PAYOUT LOG". This is specific to include ALL medical, disability, and death claims under Personal Injury Protection, Medical Payment Coverage, and other benefits which I may have in accordance with Florida statute 627.736 and the names of each biller and payee.
F. Providing notice or any request under any cooperation clause of the policy, including but not limited to: requests for EUO or IME attendance to our office as WE STAND IN THE SHOES OF THE INSURED. Any EUO or IME taken without providing us reasonable notice and allowing counsel of our choosing to attend is INVALID.
G. All notices and requests for information under Florida Statute 627.736(6)(b) are to be directed to our attorney, PHILLIP A. FRIEDMAN, ESQ. , FL LEGAL GROUP, 501 E Kennedy Blvd., Ste 810, Tampa, FL. 33602.

_

_____	_____	_____
Patient/Guardian's Name	Patient/Guardian's Signature	Date

IF PATIENT IS INCAPACITATED OR UNDER THE AGE OF 18, PLEASE INDICATE THE PATIENT NAME, GUARDIAN NAME, RELATION TO PATIENT, AND OBATIN GUADIAN SIGNATURE.

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Medical Records Release Form

In order to avoid a delay this form must be completed in its entirety.

Patient Name:_____ Maiden Name:_____

D.O.B. (Required)_____ SS#(Required)_____

Home Phone:_____ Work Phone: _____

Permission is hereby granted to Stephen Watson, MD PHD to release medical information to the individual / organization as noted below or to have records released to Stephen Watson, MD PHD:

Mail to:
Name:_____

Address:_____

City:_____ State: _____ Zip: _____

Fax to another medical entity | Call when ready for pick up | Person picking up records

(____)_____ (____)_____ _____

Please check information to be released:

- ☐ All records, excluding records from other physicians.
- ☐ Surgical Records
- ☐ Therapy reports
- ☐ Diagnostic test results
- ☐ Other _____
- ☐ Office Notes only
- ☐ X-ray/MRI films
- ☐ X-ray/MRI reports
- ☐ Patient information

This authorization will be valid for two years after the date of the patient's signature as it appears below, or by whichever comes sooner._____
Date

I understand I have the right to refuse this authorization, in writing, and Stephen Watson, MD PHD is released from all legal liability that may arise from the released information requested.

_____ _____
Signature of patient/Legal Guardian Date

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Pain Management Agreement

The purpose of this agreement is to prevent misunderstanding about certain medicines you will be taking for the control of your pain. This is also to help you and your doctor to comply with the law regarding controlled pharmaceuticals.

I understand that if I break this agreement which is essential to the trust and confidence necessary in a doctor / patient relationship which my doctor undertakes to treat me based on this agreement the doctor has the right to discharge me as a patient of the practice.

I understand that if I break this agreement, my doctor will stop prescribing these pain control medicines. In this case, my doctor will taper off the medicine over a period of several days, as necessary, to avoid withdrawal symptoms. Also, a drug dependence treatment program maybe recommended.

I have communicated, and will continue to communicate fully with my doctor about the character and intensity of my pain, the effect of the pain on my daily life, and how well the medicine is helping to relieve the pain.

I will not use illegal controlled substances, including marijuana, cocaine etc. at any time.

I will inform Dr. Stephen D Watson of all the medications I am presently taking, including all remaining refills. I will not attempt to obtain any controlled medicines which include opium pain medicines and refills, controlled stimulants, or anti-anxiety medicines from ANY OTHER DOCTOR.

I WILL NOT SHARE, SELL, OR TRADE MY MEDICATION WITH ANYONE.

I WILL SAFEGUARD MY PAIN MEDICINE/S FROM LOSS OR THEFT. LOST OR STOLEN MEDICINES WILL NOT BE REPLACED.

I UNDERSTAND THAT DR STEPHEN D WATSON RESERVES THE RIGHT TO TERMINATE MY CAREAND TREATMENT IF SUCH IS THE CASE ANY ANYTIME.

Please don't wait until you run out of medicine to call for a refill. In fact, call at least two days ahead. In order to protect you, your doctor must review your medical file before renewing a prescription. Therefore please do not call for medications after hours or on weekends when records are unavailable. It could take up to 48 hours after you call before your doctor can review your file and call in any prescription. The files are reviewed and prescriptions are called to pharmacies at the end of office hours after all patients have been seen. By law, doctors cannot order refills for certain narcotics over the phone. A written prescription is required in those cases.

I have read, understand, and agree with ALL of the above mentioned. I agree to use _____ for my PHARMACY, located at_____ with telephone number _____, for filling prescriptions for all my pain medicine(s).

_____ _____ _____

Patient Name (Print) Patient Signature Date

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(Please P rint Clearly)

Notice Of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

At Innovative Spine Care, we have always kept your health information secure and confidential. The Health Insurance Portability and Accountability Act hat requires us to continue maintaining your privacy, to give you this notice and to follow the terms of this notice. The law permits us to use or disclose your health information to those involved in your treatment. For example, reviews of your file by a specialist doctor whom we may involve in your care. We may use or disclose your health information for payment of your services. For example, we may send a report of your progress to your insurance company.

We may use or disclose your health information for our normal healthcare operations. For example, one of our staff will enter your information into our computer. We may use your information to contact you. For example, we may send newsletters or other information. We may also want to call and remind you about your appointments. If you are not home, we may leave this information on your answering machine or with the person who answers the telephone. In an emergency, we may disclose your health information to a family member or another person responsible for your care. We may release some or all of your health information when required by law. If this practice is sold, your information will become the property of the new owner.

Except as described above, this practice will not use or disclose your health information without your prior written authorization. You may request in writing that we not use or disclose your health information as described above. We will let you know if we can fulfill your request.

You have the right to transfer copies of your health information to another practice. We will mail your files for you. You have a right to receive a copy of your health information, with a few exceptions. Please provide us with a written request regarding the information you want to have copied, however, we may charge you a reasonable fee for the copies.

You have the right to request and amend your health information. Please provide us with your request to make changes in writing. If you wish to include a statement in your file, please provide it to us in writing. We may or may not make the changes that you request, but will be happy to include your statement in your file. If we agree to an amendment or change, we will neither move nor alter earlier documents, but will add new information.

You have the right to receive a copy of this notice at any time upon request.

If we change any details of this notice we will notify you in writing.

You may file a complaint with the Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, Washington, D.C. 20201. You will not be retaliated against for filing a complaint. However, before filing a complaint, or for more information or assistance regarding your health information privacy, please contact our Privacy Officer: Heather Parker at (813) 920-3022. This notice went into effect on October 01, 2007.

Acknowledgement: I have read, understand, and agree with the above Notice of Privacy Practice.

Patient/Guardian (Please Print Name)	Patient/Guardian (Signature)	Date

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Please Print Clearly)

Patient Acknowledgement

I am a patient of Innovative Spine Care (hereby known as ISC or "Provider"), hereby acknowledge that Provider does NOT have a provider agreement or contract with any health plan.

Provider will not be submitting claims to any health plan carrier for any services including for out of network benefits.

- Patient agrees not to submit claim/s for services rendered to any health plan carrier behalf of ISC.

I further acknowledge and understand that I will be responsible for payment in full for all Services rendered to me by provider; In lieu of Provider billing me or any Health Plan carrier for my services, Provider will enter into a Letter of Protection ("LOP") with my attorney whereby Provider will be compensated for all Services he/she provides to me, as a direct or indirect result of my personal injury case, from the proceeds of my settlement of said personal injury case; and the compensation that Provider will receive under the LOP will likely exceed the compensation that Provider would have received if the Provider would have submitted claims to any Health Plan for my services, and I believe that such additional compensation is equitable in the light of the nature of the services that Provider will be furnishing to me.

I have read and understood all the statements above. I acknowledge and understand that I have a right to consult with legal counsel before signing this Patient Acknowledgement and Waiver. I hereby execute this Patient Acknowledgement and Waiver voluntarily, knowledgeable and intentionally.
Please do not give your health insurance cards to the office staff of ISC.

Patient/Guardian Signature: _____ Date:_____

Attorney Acknowledgment and Agreement
The Attorney does hereby understand and acknowledges that their client or our patient knowingly and knowledgeably is of the understanding that the Provider is not under any contractual obligation with any health plan. Provider will not be submitting claims for services rendered to any health plan carrier including any out of network benefits. The attorney agrees never to bill any health plan carrier for services rendered for their client on behalf of ISC.

Attorney Signature: _____ Date:_____

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Please Print Clearly)

Patient Pain History

Name _____ DOB _____ Age ____ Date. _____

Pain level today: 0 1 2 3 4 5 6 7 8 9 10

Previous back surgery? Yes No

Would you describe your pain as: Constant Intermittent

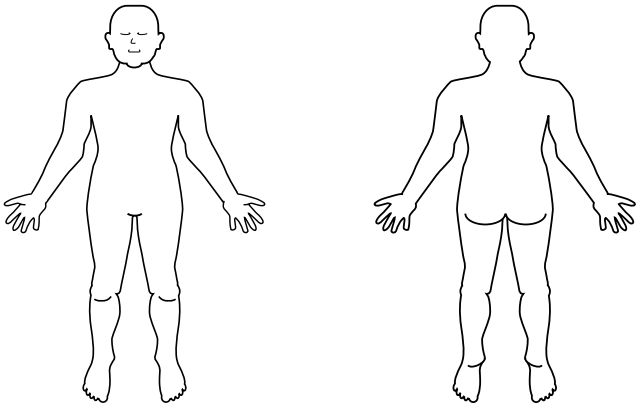
Does your pain disrupt your sleep? Yes No

Where do you have pain? (indicate on the diagram at right)

How and when did your pain begin?

_____

_____



Indicate the location of your PAIN in black and NUMBNESS in RED on the diagram

What is the intensity of your pain? Burning Stabbing Pressure Electric Sharp Dull Aching Throbbing Gnawing Shooting Numbness Tingling Other _____

What makes your pain worst? _____

What makes your pain better? _____

Can you walk? Yes No

Do you use an assistive device? Cane Walker Wheelchair Scooter Crutches None Other _____

What activities are you prevented from doing? _____

_____

Please list all previously or currently used methods of pain management:

Acupuncture Massage Chiropractor Facet Block Trigger Point Injection Exercise Physical Therapy Epidural Injection Nerve Block Hypnosis Nerve Destruction Medication Acupressure Meditation Peripheral Nerve Block Other _____

Have you ever had an MRI done? Yes No

If yes, when and where? _____

Do you work? Yes No Retired

If yes, please describe job activities _____

Current Pharmacy _____ Phone No. _____

_____ _____ _____

Patient Signature Date Reviewed by:

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Patient Medical History

Name _____ DOB _____ Age ____ Date. _____

Height: _____ WC MVA (please circle) DOI/DO A:_____

What is the main reason you are here? _____

CURRENT MEDICATIONS (List all medications-use back of this sheet if you need more room)

MEDICATION	DOSAGE	#Per Day/Frequency	Reason for Taking (if known)

ARE YOU ALLERGIC TO ANY MEDICATION: YES NO If so, what? _____

PAST MEDICAL HITORY- Check all that apply

☐ Diabetes ☐ Asthma ☐ Hypo/Hyper Thyroid ☐ High Cholesterol	☐ High Blood Pressure ☐ Bronchitis or Emphysema ☐ Rheumatoid Arthritis	☐ Heart Desease ☐ Pneumonia ☐ Other:_____ ☐ History of Cancer ☐ type:_____	☐ Heart Attack ☐ Ulcers ☐ Blood Clots

PAST SURGICAL HITORY- Check all that apply

☐ Appendix ☐ (Appendectomy) ☐ Gall Bladder ☐ (Cholecystectomy) ☐ Heart Bypass	☐ Prostate ☐ Breast Surgery ☐ Back Surgery ☐ Total Joint ☐ Replacement	☐ Tonsillectomy ☐ Hysterectomy ☐ Arthroscopy	☐ Other:_____ ☐ _____ ☐ _____ ☐ _____ ☐ _____

Family Medical History

Has anyone in your immediate family died of heart disease: YES NO _____

Has anyone in your family had an adverse reaction to anesthesia: YES NO _____

Has anyone in your family had an adverse reaction to Latex: YES NO _____

List any medical illnesses that run in your family: _____

Social History

Who do you live with now: SPOUSE BY YOURSELF OTHER FAMILY FRIENDS OTHER _____

Do you smoke tobacco? YES NO How many?_____ packs per day How long? _____years

Do you drink alcohol? YES NO How many?_____ drinks per day How long? _____years

DO YOU NOW OR HAVE YOU HAD ANY PROBLEMS RELATED TO THE FOLLOWING?

Constitutional Symptom			Eyes			Allergic Ear/Nose/Throat			Genitourinary				
Fever	Y	N	Blurred Vision	Y	N	Hay Fever	Y	N	Ear Infection	Y	N	Urine Infection	Y N
Chills	Y	N	Double Vision	Y	N	Drug Allergies	Y	N	Sore Throat	Y	N	Painful Urination	Y N
Headache	Y	N	Pain	Y	N	Sinus Problem	Y	N	Urinary Frequency	Y	N		
Other	Y	N	Other _____			Other _____			Other _____			Other _____	

Gastrointestional			Neurological			Endocrine			Respiratory			Hemotologic/Lymphatic		
Abdominal Pain	Y	N	Tremors	Y	N	Excessive Thirst	Y	N	Frequent Cough	Y	N	Swollen Glands	Y	N
Nausea/Vomiting	Y	N	Dizzy Spells	Y	N	Too hot/cold	Y	N	Short of Breath	Y	N	Blood Clots	Y	N
Rectal Bleeding	Y	N	Numbness	Y	N	Tired/Sluggish	Y	N	Wheezing	Y	N	Bleeding Problem	Y	N

Cardiovascular			Integumentary			Musculoskeletal			Psychologic History			Other Medical Condition(s)
Chest Pain	Y	N	Skin Rash	Y	N	Joint Pain	Y	N	Depression	Y	N	_____
Varicose	Y	N	Boils	Y	N	Neck Pain	Y	N	Bipolar Disorder	Y	N	_____
High B.P.	Y	N	Persistent Itch	Y	N	Back Pain	Y	N	Schizophrenia	Y	N	_____
Other _____			Other _____			Other _____			Other _____			_____

Please use the back of this form if you need more room to write out your answers to any of the above questions

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Patient Questionaire

PATIENT NAME: _____

DATE OF ACCIDENT: _____/_____/_____LOCATION OF ACCIDENT: _____

Describe The Accident In Your Own Words: _____

_____

_____

Were You Knocked Unconscious? YES NO If yes, how long were you unconscious?_____

Did You Feel Pain Immediately? YES NO If yes, where did you feel pain? _____

Did You Go To Hospital? YES NO If yes, where did you stay? _____

Were Xrays Taken? YES NO

Were Mri'S Taken? YES NO

Were Ct Scans taken? YES NO

Were Medications Given? YES NO If yes, what medications did you take? _____

What Was Your Diagnosis? _____

Have You Been Treated By Another Physician Since The Accident? Yes No

(If you have been treated by another physician, please fill in the Doctor's information below and circle any specialties that apply.)

DR NAME: _____ MD DC PT ORTHO PHONE: _____

DR NAME: _____ MD DC PT ORTHO PHONE: _____

DR NAME: _____ MD DC PT ORTHO PHONE: _____

Did You Have Symptoms Prior To The Accident? YES NO

Please circle the term that best describes your current symptoms? SAME WORSE IMPROVING

Were you wearing a seatbelt? YES NO

Were you the Driver or a Passenger? _____

If you were the passenger, where you sitting in the front or rear of the vehicle? _____

Where was the vehicle struck? FRONT REAR DRIVERS SIDE PASSEGER OTHER: _____

Have you ever been in an auto accident before? YES NO

If you have been in a previous accident, please list the date(s) and any injuries you may have sustained:

_____

_____

_____