Family Chiropractic
Ron Wilcox, D.C.

Personal Injury
204 Pinehurst Dr. SW, Ste. 103, Tumwater, WA 98501
Tel: (360) 352-8112 • Fax: (360) 352-8113

Patient Name: _____ D.O.B.: _____/_____/_____

Do you have Person Injury Protection: □Yes □No *If Yes, Complete the following with **YOUR** insurance information:*

- Insurance Payer: _____ Claim #: _____

  Claims Manager: _____ Tel.#: _____

  Is this your Insurance? □Yes □No Or a 3rd Party Insurance claim? □Yes □No

Did you Retain an Attorney: □Yes □No *If Yes, Complete the following:*

- Law Firm: _____ Attorney Name: _____

  Paralegal: _____ Tel.#: _____

Do you have health insurance: □Yes □No *If Yes, please be sure you present your insurance card to the receptionist.*

Date of Accident: _____/_____/_____ Decribe how you were injured: _____

_____

Describe Current Symptoms: _____

Please list in order with the most painful condition first:

1. _____ 2._____

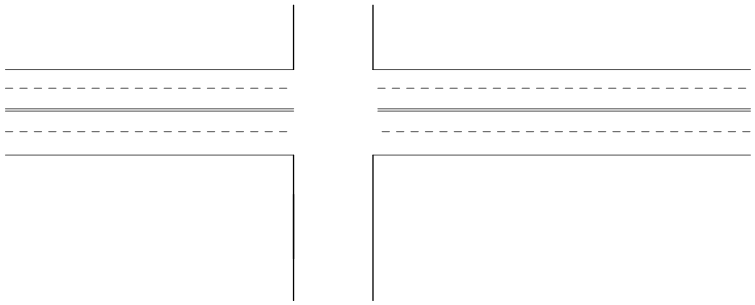
3. _____ 4._____

Were you: □Driver □Front Passenger □Back Passenger
Using a seatbelt: □Yes □No If Yes, with Shoulder restraint: □Yes □No
Were you aware of the impending impact: □Yes □No *If Yes, describe how you braced for impact*: _____
_____
Which way were you struck: □Front □Back □Driver Side □Passenger Side
Were you able to self-extricate from the vehicle: □Yes □No Were you unconscious: □Yes □No

Please use the diagram to indicate how the accident occurred:

Your Vehicle △

Other Vehicle □



Have you seen another provider for this injury? □Yes □No *If Yes, please complete the following*:

- When: _____/_____/_____ Name of Provider/Facility: _____
- Diagnostics Performed: X-rays: □Yes □No MRI: □Yes □No If yes, Where:_____
- Treament Rendered: Medications: □Yes □No If Yes, list:_____

  Massage Therapy: □Yes □No Spinal Manipulation: □Yes □No Physical Therapy: □Yes □No

  If yes, list provider(s): _____

On the pictures below, use the key on the left to shade in the areas where you are currently experiencing discomfort:

Key:
Numbness
- - - - - - -

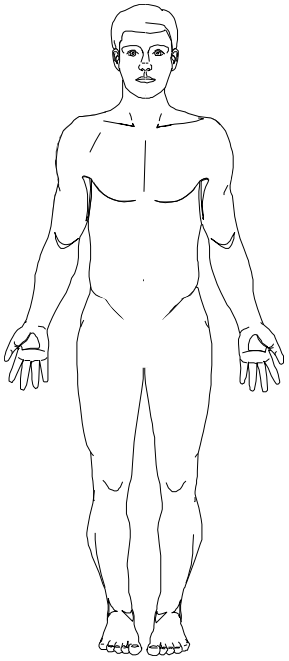
Pins and Needles
oooooooo

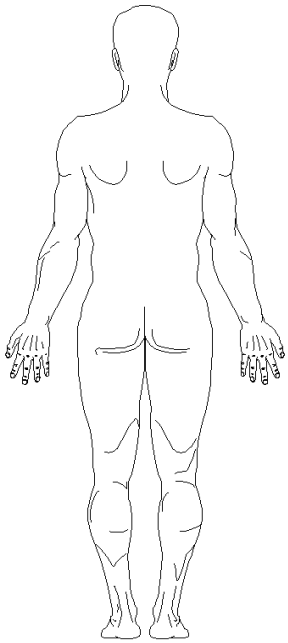
Burning
xxxxxxxx

Stabbing/Sharp
////////////////

Aching/Dull
****

Popping/Clicking
P P P





ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to Dr. Wilcox all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature _____ **Date**_____

Relationship if patient is a minor_____