PRIME MEDICINE, LLC

AUTOMOBILE ACCIDENT QUESTIONNAIRE

(This form must be completed prior to visit)

Date: ____________________

Dear Patient:
We need this confidential information answered completely to help us assess your need for care.
Thank You.

General Information:

Name: ______________________________

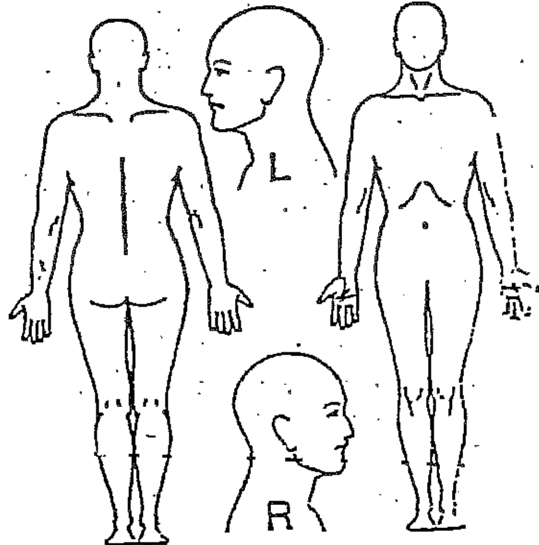
Nature of Accident:

1. What was the time and date of this present injury? __________ AM / PM ____/____/____
2. Please explain in detail how your accident happened. ____
3. Were you: _____ Driver ______ Passenger _____ Front Seat ______ Back Seat
4. Where you struck from: _______ Behind ______ Front _______ Left Side _______ Right Side
5. How many cars were involved in the accident? ______________
6. Were you wearing a seat belt? ______________ Other protective Devices? ______________
7. Did you come in contact with any other objects in the car? __________ If yes, what objects (i.e. windshield, steering wheel, door frame.....)
8. What parts of your body came in contact with the above Object (s)? ______________________________
9. Were you unconscious as a result of the injury? ________
10. Were you bleeding as a result of the injury? __________

SHOW AREA(S) OF PAIN OR UNUSUAL FEELING IMMEDIATELY

Mark the areas on this body where you felt the described sensations. Use the appropriate symbols in all affected areas.

Numbness	Pins/Needles	Burning	Aching	Stabbing
xxxxxxx	....	000000	wwwwww	IIIIIII
xxxxxxx	....	000000	wwwwww	IIIIIII



11. Where did you feel pain or unusual feeling immediately after the accident? (*Please show the areas on the diagram also.*) ______________________________
12. Were the police notified? ____________

13. Where were you taken after the accident? ______________________

14. What treatment did you receive? ______________________
____

15. Was any other doctor consulted after your accident? ______________________

16. If yes, what was the doctor's name? ______________ __DC __M.D. __DO __DDS

17. Describe the doctor's diagnosis? ______________________
____

18. What treatment did you receive? ______________________

19. Are you still under a doctor's care? ______ If yes, please explain. ______________________
____

Past History:

20. Have you ever injured this area before? _____ If yes, when? ______________________

21. Have you been involved in any previous accidents of any kind (personal injury, automobile accident or workers compensation)? If yes, please explain dates and details ______________________
____

22. Have you enjoyed good health prior to this accident? _____ If no, please explain (i.e., illness or injuries.)
____

Present Information/ Disability:

23. Have you returned to work? _____ If yes, date returned to work ______________________

24. Job description ______________________

25. Are your work activities restricted as a result of this accident? _____ If yes, please explain ______________________
____

26. Do you notice any restrictions as a result of this injury? ______ If yes, please describe. ______________________
____

27. Since this injury are your symptoms: improving ________, getting worse ________, or the same ________

Please explain ______________________

Legal Representation

28. Have you retained an attorney? ______ If yes, name and address ______________________
____

I certify that I have read and understand the above information. To the best of my knowledge the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

____
Patients Signature

____
Date

____
Date

____
Doctors Signature

PRIME MEDICINE, LLC

Internal Medicine

12150 Annapolis Road, Suite 308
Glenn Dale, MD 20769
Tel: 301464-3020
Fax: 301-262-8703

THIS FORM MUST BE COMPLETED PRIOR TO VISIT

PATIENT NAME________________________ S.S. #________________________

INSURED NAME ON POLICY ____

HAS ACCIDENT BEEN REPORTED TO INS. CO/ AGENT Y / N (CIRCLE ONE)

PATIENTS INSURANCE CO. ____________________ TEL ( ) ________________
FAX________________

MAILING ADDRESS____

CLAIM # ____

DATE OF ACCIDENT ________________

ADJUSTOR ____

HAS " PIP PACKAGE" BEEN SENT TO INSURANCE CO. Y / N DATE ____________

ADDITIONAL COMMENTS

____

____

ASSIGNMENT OF BENEFITS

I UNDERSTAND THE ABOVE TERMS OF MY INSURANCE COVERAGE AND AGREE THAT I AM ULTIMATELY RESPONSIBLE FOR PAYMENT OF ALL SERVICES RENDERED. I ASSIGN PAYMENT OF BENEFITS DIRECTLY TO PRIME MEDICINE. LLC 121510 ANNAPOLIS ROAD, SUITE 308 GLENN DALE MD. 20769.

PATIENTS SIGNATURE________________________ DATE ________________