Dr. John Bellomo
*Director*

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# PERSONAL INJURY QUESTIONNAIRE

Name:_____ Date: _____

Cell Phone: _____ Home Phone: _____

Address: _____ City/State/Zip: _____

Email Address: _____ Age _____ Birth date: _____

Sex: M F Employer's Name: _____

Your Car Insurance Name: _____ Your Policy Number: _____

Your Claim Representative's Name & Phone Number: _____

Your Car Insurance Claim Number: _____

Name on policy if other than self: _____

**Skip to next section if you were responsible for the automobile accident.**

Responsible Party's Name (person who caused the accident): _____

Responsible Party's Car Insurance Name: _____

Responsible Party's Claim Number: _____

Responsible Party's Claim Respresentative's Name & Phone Number: _____

**Skip to next section if you do not have an attorney.**

Attorney's Name and Phone Number: _____

Attorney's Address: _____

## Nature of Accident

Date of Accident: _____ Time of Day: _____ AM/PM Were you wearing seatbelts? _____

Were you a: _____ Driver _____ Passenger _____ Front Seat Passenger _____ Back Seat Passenger

Number of people in your vehicle: _____

## Nature of Accident (continued)

What direction were you headed? (Please Circle) North South East West

What street were you traveling on? _____

What direction was the other vehicle headed? (Please Circle) North South East West

What street was the other vehicle traveling on? _____

Were you struck from: _____ Behind _____ Front _____ Left Side _____Right Side

Approximate speed of your car: _____ Approximate speed of other car: _____

Were you knocked unconscious? _____Yes _____ No If yes, for how long? _____

Were the police notified? _____ Yes _____ No

In your words, please describe the accident in full detail:

_____

_____

_____

Did you have any physical complaints BEFORE the accident? _____ Yes _____ No

If yes, please describe in detail: _____

- Please describe how you felt:
  - During the accident: _____
  - Immediately after the accident: _____
  - Later that day: _____
  - The next day: _____

What are your PRESENT complaints and symptoms? _____

_____

Do you have any congenital factors ( from birth), which relate to this problem? _____ Yes _____ NO

If yes, please describe: _____

Do you have any previous illnesses, which relate to this case? _____ Yes _____ No

If yes, please describe: _____

Have you ever been involved in an auto accident before: _____ Yes _____ No

If yes, please describe including date(s) and type(s) of accident(s), as well as, injur(ies): _____

_____

## Nature of Accident (continued)

Where were you taken after the accident? _____

Have you been treated by another doctor since the accident: _____ Yes _____ No

If yes, please list the doctor's name and address: _____

Since the injury occurred, are your symptoms: _____ Improving _____ Getting Worse _____ Same

Check symptoms you have noticed SINCE THE ACCIDENT:

| | | | |
|---|---|---|---|
| ( ) Headache | ( ) Irritability | ( ) Numbness in Toes | ( ) Face Flushed |
| ( ) Feet Cold | ( ) Neck Pain | ( ) Shortness of Breath | ( ) Buzzing in Ears |
| ( ) Hands Cold | ( ) Chest Pain | ( ) Neck Stiffness | ( ) Dizziness |
| ( ) Fatigue | ( ) Loss of Balance | ( ) Stomach Upset | ( ) Sleeping Problems |
| ( ) Head Heavy | ( ) Depression | ( ) Fainting | ( ) Constipation |
| ( ) Back pain | ( ) Pins & Needles in Arms | ( ) Pins & Needles in legs | ( ) Loss of Smell |
| ( ) Cold Sweats | ( ) Nervousness | ( ) Light bothers eyes | ( ) Loss of Memory |
| ( ) Loss of Taste | ( ) Fever | ( )Tension | ( ) Other |
| ( ) Ears Ring | ( ) Diarrhea | ( ) Numbness in : _____ | |

Have you lost time from work as a result of this accident? _____ Yes _____ No

If yes, complete these questions:

- Last day worked: _____
- Type of employment: _____
- Present Salary: _____
- Are you being compensated for time lost from work? _____ Yes _____ No
    - If yes, please state the type of compensation you are receiving: _____

Do you notice any activity restrictions as a result of this injury? _____ Yes _____ No

If yes, please describe in detail: _____

_____

Date: _____ Signature: _____

"Any person who knowingly and with intent to injure, defraud, or deceive any employer or employee, insurance company, or self-insured program, files a statement of claim containing any false or misleading information is guilty of a felony of the third degree."

DO NOT DETACH

**AUTHORIZATION FOR MEDICAL INFORMATION**

THIS AUTHORIZATION OR PHOTOCOPY HEREOF, WILL AUTHORIZE YOU TO FURNISH ALL INFORMATION YOU MAY HAVE REGARDING MY CONDITION WHILE YOUR OBSERVATION OR TREATMENT, INCLUDING THE HISTORY OBTAINED, X-RAY AND PHYSICAL FINDINGS DIAGNOSIS AND PROGNOSIS, YOU ARE AUTHORIZED TO PROVIDE THIS INFORMATION IN ACCORDANCE WITH THE FLORIDA "NO FAULT" AUTO INSURANCE LAW (CHAPTER 71 252F.S.).

Date: _____ Signature: _____

DO NOT DETACH

**AUTHORIZATION FOR WAGE AND SALARY INFORMATION**

THIS AUTHORIZATION OR PHOTOCOPY HEREOF, WILL AUTHORIZE YOU TO FURNISH ALL INFORMATION YOU MAY HAVE REGARDING MY WAGES OR SALARY WHILE EMPLOYED BY YOU, YOU ARE AUTHORIZED TO PROVIDE THIS INFORMATION IN ACCORDANCE WITH THE FLORIDA "NO FAULT" AUTO INSURANCE LAW (CHAPTER 71 252F.S.).

Date: _____ Signature: _____

Social Security No.: _____

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## ASSIGNMENT OF BENEFITS & CAUSE OF ACTION

I HEREBY AUTHORIZE AND DIRECT YOU, MY INSURANCE COMPANY AND/OR MY ATTORNEY, TO PAY DIRECTLY TO Bellomo Family Chiropractic Life Center ("assignee"), such sums as may be due and owing Assignee for the services rendered to me both by reason of accident or illness, and by reason of any other bills that are due Assignee, and to withhold such sums from any disability benefits, medical payment benefits, No-Fault benefits, or any other insurance benefits obligated to reimburse me or from any settlement, judgment or verdict on my behalf as may be necessary to adequately protect said Assignee. In the event that I do not have insurance coverage, I understand that I remain responsible for payment of services rendered. I hereby further give an irrevocable lien to said assignee against any and 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 the injuries or illness for which I have been treated by the Assignee. This is to act as an assignment of my rights and benefits to the extent of the Assignee's service provided. In the event my insurance company is obligated to make payment to me upon charges made by the Assignee for its services refuses to make such payment, upon such causes of action, that I might have or that might exist in my favor against such company and authorized Assignee to prosecute said cause of action either in my name or Assignee's name and further I authorize Assignee to persecute said cause of action wither in my name or Assignee's name and further, I authorize Assignee to compromise, settle, or otherwise resolve said claim of action as they see fit.

## DIRECTION OF PAYMENT

I hereby authorize any insurance company or attorney to pay directly to Assignee the amount of this and/or any future bills for services rendered to me. I also agree to pay in a current manner any difference between the total charges and the amount pain by the company directly to Assignee.

## PIP LOG & DEC SHEET REQUEST

I hereby authorize Assignee to release any information requested that is pertinent to my case to my insurance company or attorney involved in this case. Pursuant to 627.4137 Florida Statutes (2001), I hereby request a copy of the PIP Log and Declaration Sheet, which reflects the policy limits available at the time of this accident, to be provided to this Assignee. I hereby authorize this Assignee to request and receive a copy of my PIP Log periodically as they deem necessary. If any term or provision of this Assignment, Lien and Authorization, or the application of such term or provision to persons or circumstances other than those as to which it is held invalid or unenforceable, shall not be affected thereby, and each term and provision of this assignment, Lien and Authorization shall be valid and enforced to the fullest extent of the law.

## RESERVATIONS OF BENEFITS

Be further advised that I am hereby placing you on notice pursuant to Florida case law should you (the insurance company/carrier) deny, reduce, or fail to pay any part of, or an entire bill which was submitted on my behalf from this health care provider, I (the assignor) and will as the assignee (health care provider) are requesting in advance that you reserve, or "act-aside," the amount you reduced or deny until the dispute is resolved. Should you submit a check to this health care provider which is less than the correct contractual amount, and contains any language referring to payment as "Full and Final Payment," I have instructed this health care provider to return the check to you (the carrier) and consider the bill still due and owing (i.e. a late payment as defined in F.S. 627.736). Additionally should the remaining amount of my benefits approach the amount where there would be inefficient funds to pay the amount you reduced, denied, or failed to pay, please notify me (the assignor) and the assignee (the health care provider) of this fact. Lastly, should my benefits become exhausted; please notify me (the assignor) and the assignee (this health care provider) of this fact.

Print Name::_____ Date: _____

**Signature: _____**

**Vehicle No-Fault Law, please complete this form and return it promptly.**

| Date: | Policyholder's Name: *(Either self, family member, friend, etc.)* | Policy Number: | Date of Accident: | Claim Number: |
|---|---|---|---|---|
| | | | | |

| Your Name: | Relationship to Policyholder: | Date of Birth: | Social Security Number: |
|---|---|---|---|
| | | | |

| Your Street Address, City, Zip code, and Apt# | Cell Phone Number: |
|---|---|
| | |

Brief description of accident and vehicles involved:

Did you own any automobile(s) on the date of this accident: Yes No If yes, please list: _____

_____

At the time of accident:

- Were you the driver of the policyholder's car? Yes No
- Were you a passenger in the policyholder's car? Yes No
- Were you a pedestrian? Yes No

**As a result of the accident were you injured?** Yes No **If YES complete the rest of this form.**

**If NO, sign here and return this form: Signature:**_____ **Date:** _____

Describe your injury:

| Were you treated by a doctor? Yes No | Date of Treatment: | Doctor's Name: |
|---|---|---|
| | | |

| If you were treated in a hospital were you an: In-Patient Out-Patient | Hospital Name: | Date of Hospitalization: |
|---|---|---|
| | | |

| Amount of medical bills to date: | Will you have more medical expenses? Yes No<br>At the time of accident were you working for your employer? Yes No |
|---|---|
| | |

| Did you lose time from work as a result of your injury? Yes No | If yes, amount of time lost to date (please enter dates) |
|---|---|
| | |

Have you received or are you eligible for benefits under:

- Any worker's compensation law: Yes No
- Employment by U.S. Government Yes No
- Military Services: Yes No

What is your average weekly salary: _____

List name of employer: _____

Any person who knowingly and with intent to injure, defraud, or deceive any insurance company, files a statement of claim containing false, incomplete, or misleading information is guilty of a felony of the third degree.

**Signature :** _____ **Date:** _____

This authorization or photocopy hereof, will authorize you to furnish all information you may have regarding my condition while under your observation or treatment, including the history obtained, x-ray, and physical findings, diagnosis, and prognosis, you are authorized to provide this information in accordance with the Florida Motor Vehicle No-Fault Law.