Back & Neck Clinic
OF NEW PRAGUE

Auto Accident Information

Patient Name _____ Today's Date _____

Date of Birth _____ Phone # _____ Gender: *Male* or *Female*

Address _____ City _____ State _____ Zip _____

Date of Accident _____ **Time of Accident** _____ AM or PM

1. Where did the accident occur? _____
2. Describe in detail how the accident happened **(very important)** _____

   _____

   _____

   _____
3. What injuries did you sustain? _____
4. Did you have any of these symptoms prior to the accident? **YES** or **NO**
   a. If yes, what symptoms did you have and when did you have them? _____

      _____
5. Have you had any other medical care for this injury? **YES** or **NO**
   a. If yes, please give the name of the facility _____
      i. Phone # _____ Location _____
6. Are you represented by an attorney? **YES** or **NO**
   a. Name _____ Phone # _____
      i. Address _____
7. Were you the **driver** or **passenger**? _____
   a. If the passenger, where were you sitting in the vehicle? _____

CONTINUE TO BACKSIDE →

(952) 758-5135
201 E Main St
New Prague, MN 56071

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Insurance Information (Referring to your Auto Insurance)

Insurance Company _____ (Copy insurance card)

Address of insurance company _____

Name of Insured _____ Policy # _____

Claim # _____

Claim Adjuster _____ **Phone #** _____

Authorization for Disclosure of Medical Information

I hereby authorize the use and/or disclosure of my health information related to my auto accident on _____, to the requestor's claims representatives and/or agents. I understand that if the organization authorized to receive the information is not a health plan or healthcare provider, the information may be further disclosed and may no longer be protected by federal privacy regulations. I further authorize The Back and Neck of New Prague to disclosure information related to the claim even if such information was created or already existed prior to the date of this authorization.

Today's Date _____

Print Patient's Name _____

Signature of Patient _____

(If patient is a minor, we need the guardian's signature)

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