



DeFabio Spine and Sports Rehab, LLC

Chiropractic • Chronic Pain • Nutrition

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LIABILITY ACCIDENT QUESTIONNAIRE

Name _____ Today's Date _____

Date of Accident _____ Location _____

Time of Accident _____ AM PM

You were Driver Passenger Pedestrian

Front seat Back seat

Using Seat belts Air bag deployed

Describe in detail how this accident occurred _____

Were you knocked unconscious? Yes No If so, how long? _____

Where did you feel pain immediately after the accident? _____

Where were you taken after the accident? _____

Was any treatment given? Yes No If yes, what type? _____

Were the police notified? Yes No

Automobile Insurance Carrier _____

Address _____ Phone _____

Policy # _____ Exp. Date _____

Responsibility Statement

I understand that liable insurance carriers may not pay for medical treatment of this injury. They will determine if treatment was authorized properly and is medically necessary under their standards. Therefore, I clearly understand that all services rendered to me are charged directly to me and I am personally responsible for any or all charges not paid by the insurance carrier.

Patient's Signature

Date