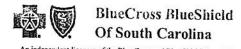
Subrogation / Workers' Compensation 1-20 at Alpine Road Columbia, SC 29219-0001 1-800-288-2227, extension 43060

Fax: 1-803-865-0654



An independent licensee of the Blue Cross and Blue Shield Association

ACCIDENT QUESTIONNAIRE

Subscriber: Address: Address:		vice:	
Dear Member:			
Our review process indicates this patient may have recresponsibility, please complete, sign and return this fo have to deny your claims. If you have previously con	mpleted a form for this accide	If we do not receive thi	
Was the injury or illness: Auto/Motorcycle Accid	entWork Related	Other Accident	No Accident
Date of the injury or illness: Describe the injury or illness and how it happened:	City/County and State	of Injury:	
Names of other family members injured:			
If yes, name and address of person causing injury: Insurance Company of person causing injury: Address and Phone #: If auto or motorcycle related, was the patient wearing If auto or motorcycle related, was the patient the drive Auto Insurance Company of Patient: Address and Phone #:	a seatbelt? YES / NO a h	Policy/Claim # :_ uster's Name: elmet? YES / NO	
If you checked "Work Related," please ans Name and address of patient's employer at the time of Have you filed a Workers' Compensation claim? If yes, name of Workers' Compensation corriers	wer the following: injury: YES / NO		
Policy/Claim # :	Adjuster's N	ame:	
Policy/Claim #: Address and Phone # Has the employer or the workers' compensation carrier	accepted or denied liability?	ACCEPTED /	DENIED
Name, address, and telephone number of your attorney	(if applicable):		
I agree that the above information is correct, and I compensation Department of BlueCross BlueShield	will not settle a claim before of South Carolina.	contacting the Subroga	ntion / Workers'
Signature	Date	T	elephone Number

ALL QUESTIONS ON THIS FORM MUST BE ANSWERED

DATE: / //				
NAME: HOME PHONE: ()				
ADDRESS: CITY:				
STATE: ZIP CODE: AGE:				
(CIRLCE ONE) SEX: M F BIRTHDATE:/				
MARITAL STATUS: MARRIED SINGLE WIDOW SEPERATED DIVORCED				
IF MARRIED, GIVE SPOUSE'S NAME:				
IF SINGLE, GIVE FATHER'S OR MOTHER'S NAME:				
EMPLOYER: PHONE: ()				
EMPLOYER ADDRESS:				
ARE YOU COVERED BY HEALTH INSURANCE? YES NO				
NAME OF INSURANCE COMPANY:				
HAVE YOU EVER BEEN IN AN AUTO ACCIDENT? YES NO				
IF YES, GIVE DATE: WERE YOU INJURED? YES NO				
IF INJURED, WHERE: NECK BACK HEAD OTHER:				
WHAT DOCTOR DID YOU SEE FOR ABOVE ACCIDENT?				
By signing you name below, you certify the accuracy of your medical and/or accident history and further certify that you present to the doctor for evaluation and/or treatment of a health related condition and for no other purpose. I hereby request and consent to the performance of medical/chiropractic care by this office. I understand and am informed that there are some risks to diagnoses and treatments. I wish to rely on the doctor to exercise judgement during the course of the procedure to act in my best interest. I have read or have had read to me, the above consent. By signing below, I consent to Lancaster One Medical to perform necessary diagnosis and treatment procedures.				
Parent's Signature:				
Authorization to Treat Minor:				

DATE OF CURRENT ACCIDENT:		TIME: AM/PM	
DATE OF FIRST SYSTEMS:			
LOCATION OF ACCIDENT? (ON WHA!			
HAVE YOU LOST ANY TIME FROM WO	ORK DUE TO THIS ACCIDENT OR	SICKNESS? YES NO	
IF YES, DATES FROM	то		
WHERE DO YOU HURT?	CHECK SYSTEMS YOU ARE HA		
□ HEADACHE	□ NECK PAIN	□ NECK STIFF	
□ MID BACK PAIN	□ LOW BACK PAIN	□ FATIGUE	
□ PAIN BETWEEN SHOULDERS	□ CHEST PAIN	□ DIZZINESS	
□ RIGHT LEG / HIP PAIN	□ LEFT LEG / HIP PAIN	□ NERVOUSNESS	
□ RIGHT ARM / SHOULDER	□ LEFT ARM / SHOULDER	□ NAUSEA	
HOW DID ACCIDENT HAPPEN?			
WERE YOU THE □ DRIVER □ I	PASSENGER		
DID YOU/DRIVER GET A TICKET?	YES NO OTHER DRIVE	ER? YES NO	
WERE YOU WEARING A SEAT BELT?	YES NO		
DID ANY PART OF YOUR BODY HIT A	NYTHING DURING ACCIDENT?	YES NO	
IF YES, WHAT BODY PART?			
DID YOUR CAR HIT THE OTHER CAR	YES NO DID OTHER CA	R HIT YOURS? YES NO	
AT THE TIME OF ACCIDENT, WERE YO	OU LOOKING - AHEAD - LEF	T 🗆 RIGHT	
DID YOU GO TO THE EMERGENCY RO	OOM? YES NO		
IF YES, WHEN? □ AFTER ACCIDEN	T □ SAME DAY □ SAME NIGH	T 🗆 LATER	
HOW DID YOU GO? □ AMBULANCE	C CAR WHICH HOSPITAL?		
WHERE YOU ADMITTED? YES N	O IF YES, DATE ADMITTE	ED:	
	DATE RELEASED:		
WERE X-RAYS TAKEN? YES NO	IF YES, WHAT BODY PA	RT?	
HAVE YOU SEEN ANY OTHER DOCTO			
IF YES, GIVE DOCTOR'S NAME:			
HIS DIAGNOSIS:		- ,	