

# Belanger Body Care

4630 200<sup>th</sup> Street S.W. Suite M  
Lynnwood, Washington 98036

## Personal Injury Information

Date: \_\_\_\_\_

**Office Policy:** I understand that I am financially responsible for all services if my Auto Insurance Carrier does not pay. Belanger Body Care will verify that the coverage is available, but it is ultimately my responsibility.

**No Show Policy:** Appointments cancelled or missed without 24 hours notice will be charged \$50.00. The time set aside for your treatment is very important to us and our desire is to help you recover. We can not give your time slot to another patient without the appropriate notification time allowed. Consider that there are many other patients that would love to have your appointment time if you give us enough time to contact them.

## Personal Injury Information Worksheet

Patient Name: \_\_\_\_\_

Date of Accident: \_\_\_\_\_

PIP Carrier: \_\_\_\_\_

Claim # : \_\_\_\_\_

Claim Manager: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Attorney: \_\_\_\_\_

Phone:: \_\_\_\_\_ Fax: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Date & Time of Accident: \_\_\_\_\_

Were you ( Please circle one )

Driver

Front Passenger

Rear left Passenger

Rear right Passenger

Number of people in your vehicle: \_\_\_\_\_

Were you wearing your seatbelt? Yes \_\_\_ No \_\_\_

Did you go to the Emergency Room Yes \_\_\_ No \_\_\_

Which Hospital: \_\_\_\_\_

Did the police come to the accident site? Yes \_\_\_ No \_\_\_

Did any part of your body strike anything in the vehicle? Yes \_\_\_ No \_\_\_

Details: \_\_\_\_\_

What did your vehicle impact? \_\_\_\_\_

( Another Vehicle, Pole, Tree, Wall )

Did the impact to your vehicle come from: (Please circle one )

Front

Rear

Right Side

Left Side

Other

In your own words please describe the accident:

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On the next page please circle all areas that are injured and indicate, to the best of your ability, what type of pain you are experiencing.

A = Ache

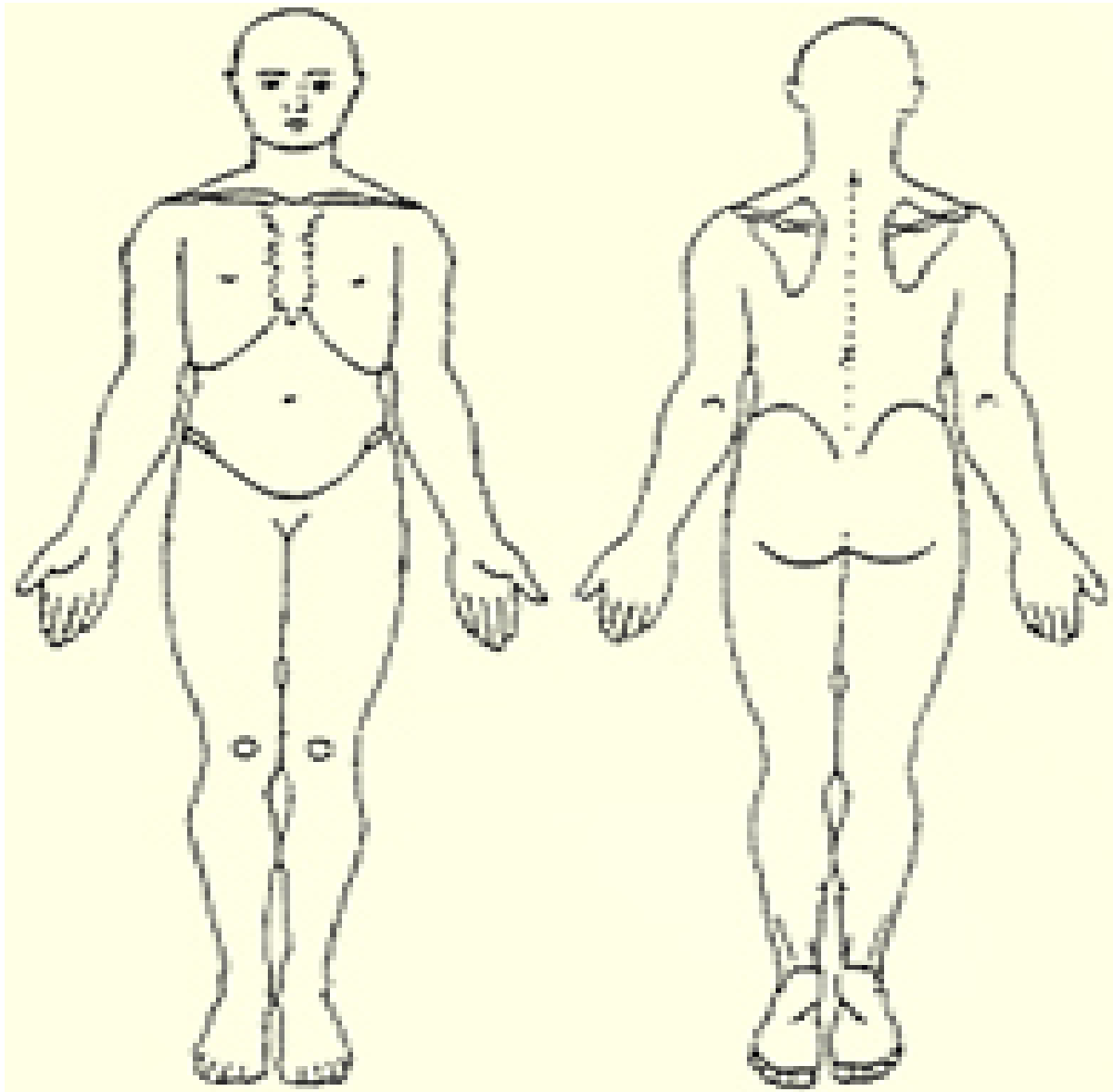
B = Burning

N = Numbness

P = Needles

S = Stabbing

O = Other



Please Rate your pain level – choose the number which best describes your pain.  
 ( 0 = No Pain    10 = Unbearable )

**Neck:**    0   1   2   3   4   5   6   7   8   9   10    **At it's worst**

**Upper Back:**    0   1   2   3   4   5   6   7   8   9   10    **At it's worst**

**Lower Back:**    0   1   2   3   4   5   6   7   8   9   10    **At it's worst**

Are you getting headaches? Yes \_\_\_ No \_\_\_    How often \_\_\_\_\_

How long do they last \_\_\_\_\_

Please describe what the pain feels like and what locations on your head.

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