AUTOMOBILE ACCIDENT QUESTIONNAIRE

PATIENT'S NAME: _____

TODAY'S DATE: _____DATE OF ACCIDENT: _____

NAME OF ATTORNEY/LAW FIRM: _____

THE FOLLOWING QUESTIONS PERTAIN TO YOU & THE INVOLVED IN THE ACCIDENT:

VEHICLE TYPE:

_____CAR _____PICKUP
_____VAN _____TRUCK
_____BUS _____STATION WAGON
_____OTHER_____

VEHICLE SIZE:

_____SUBCOMPACT _____FULL-SIZE
_____COMPACT _____MINIVAN
_____MID-SIZE _____LIGHT
_____HEAVY _____OTHER

YOUR POSITION IN THE VEHICLE:

_____DRIVER
_____PASSENGER, LOCATION: _____FRONT PASSENGER ____REAR PASSENGER ____THIRD ROW
____LEFT ____MIDDLE ____RIGHT

SPEED OF YOUR VEHICLE:

_____STOPPED _____SLOWING
_____PARKED
_____MOVING AT APPROX_____MPH

WHY VEHICLE WAS SLOWED OR STOPPED:

_____TRAFFIC LIGHT/STOP _____PARKING
_____PEDESTRIAN _____TRAFFIC
_____BUSY INTERSECTION

COLLISION TYPE:

_____DRIVER SIDE IMPACT _____HEAD ON COLLISION
_____PASSENGER SIDE IMPACT _____REAR IMPACT
_____FRONT IMPACT _____PEDESTRIAN INCIDENT

THE FOLLOWING QUESTIONS CONCERN THE OTHER VEHICLE INVOLVED IN THE ACCIDENT:

VEHICLE TYPE:

_____CAR _____PICKUP

_____VAN _____TRUCK

_____BUS _____STATION WAGON

_____OTHER: _____

VEHICLE SIZE:

_____SUBCOMPACT _____FULL-SIZE

_____COMPACT _____MINIVAN

_____MID-SIZE _____LIGHT

_____HEAVY _____OTHER

CONDITIONS AT THE TIME OF THE ACCIDENT:

TIME OF DAY:

_____FULL DAYLIGHT

_____DUSK/DAWN

_____NIGHT

ROAD CONDITIONS:

_____DRY

_____DAMP

_____WET

_____SNOW COVERED

_____ICE COVERED

_____PATCHY/ICE/SNOW

VISIBILITY:

_____EXCELLENT

_____GOOD

_____FAIR

_____POOR

VISIBILITY COMPROMISED BY:

_____BRIGHTNESS

_____DARKNESS

_____RAIN

_____SNOW

_____FOG

_____TRAFFIC

THE FOLLOWING QUESTIONS CONCERN THE MOMENT OF IMPACT OF THE ACCIDENT:

WERE YOU?

_____TOTALY UNAWARE THAT THE ACCIDENT WAS IMPENDING

_____AWARE THAT THE ACCIDENT WAS IMPENDING

_____AWARE THAT THE ACCIDENT WAS IMPENDING AND BRACED FOR IT

RESTRAINTS (CHECK ALL THAT APPLY):

_____LAP BELT

_____SHOULDER HARNESS

_____NO RESTRAINTS

IF YOU WERE THE DRIVER OF THE VEHICLE, WAS YOUR FOOT ON THE BRAKE PEDAL?

_____YES _____NO _____KNOCKED OFF BY IMPACT

WAS THE AIRBAG DEPLOYED?

_____CAR NOT EQUIPPED WITH AIRBAG

_____AIRBAG DEPLOYED

_____AIRBAG NOT DEPLOYED

IN WHAT POSITION WAS YOUR HEADREST?

_____HIGH POSITION

_____MIDDLE POSITION

_____LOW POSITION

POSITION OF YOUR HEAD AT TIME OF IMPACT:

_____FACING STRAIGHT AHEAD
_____TILTED FORWARD
_____ROTATED TO THE LEFT
_____ROTATED TO THE RIGHT

WAS YOUR HEAD THROWN…?

_____BACKWARD THEN FORWARD
_____FORWARD THEN BACKWARD
_____TO THE LEFT _____TO THE LEFT THEN RIGHT
_____TO THE RIGHT _____TO THE RIGHT THEN LEFT

POSITION OF YOUR BODY AT THE TIME OF IMPACT:

_____STRAIGHT
_____TILTED FORWARD
_____ROTATED TO THE LEFT
_____ROTATED TO THE RIGHT

WAS YOUR BODY THROWN…?

_____BACKWARD THEN FORWARD
_____FORWARD THEN BACKWARD
_____OUTSIDE VEHICLE
_____TO THE LEFT _____TO THE LEFT THEN RIGHT
_____TO THE RIGHT _____TO THE RIGHT THEN LEFT
_____ACROSS THE VEHICLE _____UNDER THE VEHICLE

DAMAGES TO THE VEHICLE YOU WERE IN:

_____INCURRED MINIMAL DAMAGE
_____INCURRED MODERATE DAMAGE
_____INCURRED SEVERE DAMAGE
_____WAS TOTALED
_____NOT KNOWN

CITATIONS:

_____NONE ISSUED
_____YOURSELF
_____DRIVER OF VEHICLE YOU WERE IN
_____DRIVER OF THE OTHER VEHICLE
_____OTHER: _____

AS A RESULT OF THE FORCE OF THE COLLISION, WHICH OBJECTS IN THE VEHICLE DID YOUR BODY STRIKE?

HEAD	RIGHT ARM	LEFT LEG
_____STEERING WHEEL	_____STEERING WHEEL	_____STEERING WHEEL
_____DASHBOARD	_____DASHBOARD	_____DASHBOARD
_____WINDSHIELD	_____WINDSHIELD	_____WINDSHIELD
_____ARM REST	_____ARM REST	_____ARM REST
_____HEAD REST	_____HEAD REST	_____HEAD REST
_____REARVIEW MIRROR	_____REARVIEW MIRROR	_____REARVIEW MIRROR
_____LEFT DOOR	_____RIGHT WINDOW	_____RIGHT WINDOW
_____CONSOLE	_____CONSOLE	_____CONSOLE
_____GEAR SHIFT	_____GEAR SHIFT	_____GEAR SHIFT
_____FRONT SEAT	_____FRONT SEAT	_____FRONT SEAT
_____BACK SEAT	_____BACK SEAT	_____BACK SEAT

LEFT ARM	**TORSO**	**RIGHT LEG**
_____STEERING WHEEL	_____STEERING WHEEL	_____STEERING WHEEL
_____DASHBOARD	_____DASHBOARD	_____DASHBOARD
_____WINDSHIELD	_____WINDSHIELD	_____WINDSHIELD
_____ARM REST	_____ARM REST	_____ARM REST
_____HEAD REST	_____HEAD REST	_____HEAD REST
_____REARVIEW MIRROR	_____REARVIEW MIRROR	_____REARVIEW MIRROR
_____LEFT DOOR	_____LEFT DOOR	_____LEFT DOOR
_____RIGHT WINDOW	_____RIGHT WINDOW	_____RIGHT WINDOW
_____CONSOLE	_____CONSOLE	_____CONSOLE
_____GEAR SHIFT	_____GEAR SHIFT	_____GEAR SHIFT
_____FRONT SEAT	_____FRONT SEAT	_____FRONT SEAT
_____BACK SEAT	_____BACK SEAT	_____BACK SEAT

WERE YOU AT FAULT FOR THE ACCIDENT?

_____YES _____NO

THE FOLLOWING QUESTIONS CONCERN THE TIME PERIOD IMMEDIATELY FOLLOWING THE ACCIDENT:

DID YOU LOSE CONSCIOUSNESS? IMMEDIATELY FOLLOWING THE ACCIDENT, DID YOU FEEL?

_____YES

_____NO

_____DIZZY _____WEAK _____DAZED

_____NERVOUS _____DISORIENTED _____NAUSEATED

WERE YOU ABLE TO WALK UNAIDED?

_____YES

_____NO

WHERE DID YOU GO?

_____DROVE HOME

_____WAS DRIVEN HOME _____WAS DRIVEN TO WORK

_____DROVE TO HOSPITAL _____DROVE TO SCHOOL

_____WAS DRIVEN TO HOSPITAL

_____WAS DRIVEN TO SCHOOL

_____TAKEN TO HOSPITAL VIA AMBULANCE

_____OTHER_____

NEXT DAY DISCOMFORT:

_____ INCREASED

_____DECREASED

_____SAME

DID YOUR MAJOR COMPLAINTS EXIST BEFORE THE ACCIDENT?

_____YES _____NO

IN WHAT AREAS DID YOU IMMEDIATELY FEEL PAIN?

_____HEAD	SHOULDER:	_____ LEFT	_____RIGHT	HIP:	_____ LEFT	_____RIGHT
_____NECK	ARM:	_____ LEFT	_____RIGHT	KNEE:	_____ LEFT	_____RIGHT
_____MID BACK	WRIST:	_____LEFT	_____RIGHT	CALF:	_____ LEFT	_____RIGHT
_____RIBS	HAND:	_____LEFT	_____RIGHT	ANKLE:	_____ LEFT	_____ RIGHT
_____CHEST	FINGERS:	_____LEFT	_____RIGHT	FOOT:	_____ LEFT	_____ RIGHT
_____ABDOMEN	BUTTOCK:	_____LEFT	_____RIGHT	TOES:	_____ LEFT	_____ RIGHT
_____LOWER BACK						
_____PELVIS						

IN WHAT AREAS DID YOU EXPERIENCE LACERATIONS (CUTS)?

_____HEAD	SHOULDER:	_____LEFT	_____RIGHT	HIP:	_____LEFT	_____RIGHT
_____NECK	ARM:	_____ LEFT	_____RIGHT	THIGH:	_____LEFT	_____RIGHT
_____UPPER BACK	ELBOW:	_____ LEFT	_____RIGHT	KNEE:	_____LEFT	_____RIGHT
_____MID BACK	WRIST:	_____ LEFT	_____RIGHT	CALF:	_____LEFT	_____RIGHT
_____RIBS	HAND:	_____ LEFT	_____RIGHT	ANKLE	_____LEFT	_____RIGHT
_____CHEST	FINGERS:	_____ LEFT	_____RIGHT	FOOT:	_____LEFT	_____RIGHT
_____ABDOMEN	BUTTOCK:	_____ LEFT	_____RIGHT	TOES:	_____LEFT	_____RIGHT
_____LOWER BACK						
_____PELVIS						

AT THE HOSPITAL, WHAT AREAS WERE RADIOGRAPHED?

_____HEAD	SHOULDER:	_____ LEFT	_____RIGHT	HIP:	_____LEFT	_____RIGHT
_____NECK	ARM:	_____ LEFT	_____RIGHT	THIGH:	_____LEFT	_____RIGHT
_____UPPER BACK	ELBOW:	_____ LEFT	_____RIGHT	KNEE:	_____LEFT	_____RIGHT
_____MID BACK	WRIST:	_____ LEFT	_____RIGHT	CALF:	_____LEFT	_____RIGHT
_____RIBS	HAND:	_____ LEFT	_____RIGHT	ANKLE:	_____LEFT	_____RIGHT
_____CHEST	FINGERS:	_____ LEFT	_____RIGHT	FOOT:	_____LEFT	_____RIGHT
_____ABDOMEN	BUTTOCK:	_____ LEFT	_____RIGHT	TOES:	_____LEFT	_____RIGHT
_____LOWER BACK						
_____PELVIS						

WHERE DID YOU EXPERIENCE PAIN ON THE DAY FOLLOWING THE ACCIDENT?

_____HEAD	SHOULDER:	_____ LEFT	_____RIGHT	HIP:	_____ LEFT	_____RIGHT
_____NECK	ARM:	_____ LEFT	_____RIGHT	THIGH:	_____ LEFT	_____RIGHT
_____UPPER BACK	ELBOW:	_____ LEFT	_____RIGHT	KNEE:	_____ LEFT	_____RIGHT
_____MID BACK	WRIST:	_____ LEFT	_____RIGHT	CALF:	_____ LEFT	_____RIGHT
_____RIBS	HAND:	_____ LEFT	_____RIGHT	ANKLE:	_____ LEFT	_____RIGHT
_____CHEST	FINGERS:	_____ LEFT	_____RIGHT	FOOT:	_____ LEFT	_____RIGHT
_____ABDOMEN	BUTTOCK	_____ LEFT	_____RIGHT	TOES:	_____ LEFT	_____RIGHT
_____LOWER BACK						
_____PELVIS						

ST LUKE'S REGIONAL HEALTHCARE, PLC
DR. JOSEPH B. GHALY, MD

6030 S FLORIDA AVENUE, SUITE 110 - LAKELAND, FLORIDA 33813
PHONE: (863) 644-9800 - FAX (863) 644-9822

IRREVOCABLE ASSIGNMENT OF BENEFITS

1. I hereby authorize St Luke's Regional Healthcare, PLC, and/or any medical services provider there including or without limitations, to bill my insurance company or companies directly for any services rendered to me for any insurance benefits otherwise available to me.

2. I hereby instruct and direct any insurance company or other collateral source for which I am entitled to benefits which should pay monies owed as a result of medical services rendered by St Luke's Regional Healthcare, PLC to make payment in the name of and directly to St Luke's Regional Healthcare, PLC.

3. I further instruct my insurance company to cooperate with the above-captioned healthcare provider in resolving all medical billing disputes. Cooperation includes but is not limited to providing all declaration pages, PIP Logs, payout ledgers, explanations of benefits, copies of checks, and any and all other documents or information to St Luke's Regional Healthcare, PLC or any attorney, employees, or other representative acting on behalf of St Luke's Regional Healthcare, PLC. I further direct and authorize you to speak to an attorney, employee, or any other representative of St Luke's Regional Healthcare, PLC or anyone acting on their behalf over the phone and provide them with any and all information you may have, or documentation not previously listed above that they may request

4. St Luke's Healthcare, PLC is authorized to file suit on my behalf against my insurance company that denies benefits for medical services rendered to me and to collect any damages awarded or settlement of monies for services rendered, plus interest, costs and reasonable attorney's fees. I understand that in any such lawsuit, my name or other identifying information will need to be included in and/or portions of my medical file attached to pleadings and/or formal discovery. I waive any confidentiality of my records and/or information to the extent necessary to prosecute a claim against the insurance company or any other responsible party.

These payment instructions are for the benefits payable to me under my current insurance policy as payment towards the total charges for professional services rendered. I, as the patient, have agreed to remain personally liable for the amounts billed by the healthcare provider regardless of the amount paid by the insurance company unless ordered otherwise by a court of law. I fully understand that said healthcare services are being provided to me in consideration for an unconditional promise to pay for me providing these instructions to my insurance company. I, as the patient, further agree to be liable for reasonable attorney's fees and costs incurred in collection of any delinquent accounts or unpaid balances.

By executing this document, I am placing my insurance company on notice that this is a direct assignment of benefits pursuant to Florida law. As the insured or beneficiary of said insurance policy, I am irrevocably assigning whatever rights I have under my policy of insurance and under Florida law to this healthcare provider. A photocopy of these instructions shall be considered as effective and valid as the original.

_____	_____	_____
Patient Signature	Date	Acceptance of Provider

Revised 4/05/23 (LG)

Joseph Ghaly, MD

Date:_____

I am a physician licensed in Florida under Florida Statute (hereinafter "F.S") 458 or 459 or an advanced registered nurse practitioner licensed under F.S. 464. Or a physician assistant licensed under F.S. 456.

I examined patient_____ with a date of birth of_____ and determined that he/she has an emergency medical condition.

An emergency medical condition is defined pursuant to Florida Statute 627.736 as "a medical condition manifesting itself by acute symptoms of sufficient severity, which may include severe pain, such that the absence of immediate medical attention could reasonably be expected to result in serious jeopardy to patient health, and/or serious impairment to bodily functions, and/or serious dysfunction of any bodily organ or part."

Practitioner Name: _____ Youssef B Ghaly, MD

_____ Nkechinyere Esoga, APRN

_____ Julianna Carter, PA-C

Practitioner Signature: _____

Date of Accident: _____

Claim No: _____

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