

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:

VEHICLE SIZE:

____ CAR	____ PICKUP	____ SUBCOMPACT	____ FULL-SIZE
____ VAN	____ TRUCK	____ COMPACT	____ MINIVAN
____ BUS	____ STATION WAGON	____ MID-SIZE	____ LIGHT
____ OTHER _____		____ HEAVY	____ OTHER

YOUR POSITION IN THE VEHICLE:

____ DRIVER
____ PASSENGER, LOCATION: ____ FRONT PASSENGER ____ REAR PASSENGER ____ THIRD ROW
____ LEFT ____ MIDDLE ____ RIGHT

SPEED OF YOUR VEHICLE:

WHY VEHICLE WAS SLOWED OR STOPPED:

____ STOPPED	____ SLOWING	____ TRAFFIC LIGHT/STOP	____ PARKING
____ PARKED		____ PEDESTRIAN	____ TRAFFIC
____ MOVING AT APPROX ____ MPH		____ 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?

TOTALLY 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:

WAS YOUR HEAD THROWN...?

___ FACING STRAIGHT AHEAD

___ BACKWARD THEN FORWARD

___ TILTED FORWARD

___ FORWARD THEN BACKWARD

___ ROTATED TO THE LEFT

___ TO THE LEFT ___ TO THE LEFT THEN RIGHT

___ ROTATED TO THE RIGHT

___ TO THE RIGHT ___ TO THE RIGHT THEN LEFT

POSITION OF YOUR BODY AT THE TIME OF IMPACT:

WAS YOUR BODY THROWN...?

___ STRAIGHT

___ BACKWARD THEN FORWARD

___ TILTED FORWARD

___ FORWARD THEN BACKWARD

___ ROTATED TO THE LEFT

___ OUTSIDE VEHICLE

___ ROTATED TO THE RIGHT

___ 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:

CITATIONS:

___ INCURRED MINIMAL DAMAGE

___ NONE ISSUED

___ INCURRED MODERATE DAMAGE

___ YOURSELF

___ INCURRED SEVERE DAMAGE

___ DRIVER OF VEHICLE YOU WERE IN

___ WAS TOTALED

___ DRIVER OF THE OTHER VEHICLE

___ NOT KNOWN

___ 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

- STEERING WHEEL
- DASHBOARD
- WINDSHIELD
- ARM REST
- HEAD REST
- REARVIEW MIRROR
- LEFT DOOR
- RIGHT WINDOW
- CONSOLE
- GEAR SHIFT
- FRONT SEAT
- BACK SEAT

TORSO

- STEERING WHEEL
- DASHBOARD
- WINDSHIELD
- ARM REST
- HEAD REST
- REARVIEW MIRROR
- LEFT DOOR
- RIGHT WINDOW
- CONSOLE
- GEAR SHIFT
- FRONT SEAT
- BACK SEAT

RIGHT LEG

- STEERING WHEEL
- DASHBOARD
- WINDSHIELD
- ARM REST
- HEAD REST
- REARVIEW MIRROR
- LEFT DOOR
- RIGHT WINDOW
- CONSOLE
- GEAR SHIFT
- FRONT 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 DIZZY WEAK DAZED

NO 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



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
_____ Jeanette Diyorio, APRN
_____ Julianna Carter, PA-C

Practitioner Signature: _____

Date of Accident: _____

Claim No: _____

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