H. Charles Jelinek, Jr. D.D.S.
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(703) 560-8700

History of Accident

Patient Name: _____ (Last) _____ (First) ____ (MI) _____ (Preferred Name)

What was the date of your accident?

_____

Were you?

◯ Passenger in a Vehicle ◯ Driver of a Vehicle ◯ A Pedestrian

Was this a work related incident?

◯ Yes ◯ No

Did you?

☐ Hit an Object ☐ Get Hit by an Object ☐ Fall

If in a vehicle, where was the vehicle hit?

☐ Front End ☐ Rear End ☐ Front Right ☐ Front Left
☐ Rear Right ☐ Rear Left ☐ Driver's Side ☐ Passenger's Side
☐ Head On

Please check any areas of direct trauma:

☐ Forehead ☐ Face ☐ Chin ☐ Side of Head
☐ Back of Head ☐ Top of Head ☐ Teeth ☐ Jaw
☐ Other _____

Did any of these areas forcibly strike the following:

☐ Windshield ☐ Steering Wheel ☐ Passenger's Window ☐ Driver's Window
☐ Passenger's Door ☐ Driver's Door ☐ Headrest ☐ Seat
☐ Roof ☐ Interior of Car ☐ Other _____

Were any of the following areas painful shortly after the accident?

☐ Head ☐ Neck ☐ Face ☐ Jaw ☐ Left Shoulder
☐ Right Shoulder ☐ Left Arm ☐ Right Arm ☐ Lower Back ☐ Upper Back
☐ Other _____

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Briefly describe the history of symptoms, accident or incident:

Did you go to the hospital?

◯ Yes ◯ No

If yes, were you taken by car, ambulance or helicopter?

Did you have x-rays taken while in the hospital?

◯ Yes ◯ No

When were you released?

What was the name of the hospital?

Has a doctor or dentist ever diagnosed you with a TMJ disorder prior to this accident?

◯ Yes ◯ No

If yes, please explain:

Response Date: