Motor Vehicle Accident

Patient Name: _____ Date: _____

Date of Accident:_____ Time of Accident: _____ ❑ a.m. ❑ p.m.

Number of People In Your Vehicle?_____ Were you the:❑Driver ❑Front Passenger ❑Rear Passenger

If a traffic violation was issues, to who was it issued? _____

Did the police come to the Accident Site? ❑Yes ❑No Were you wearing a seatbeat? ❑Yes ❑No
Was a police report filed? ❑Yes ❑No Was this vehicle equipped with airbags? ❑Yes ❑No
Were there any witnesses? ❑Yes ❑No If Yes, did it/they inflate? ❑Yes ❑No

What did your vehicle impact? ❑Another Vehicle ❑ Other _____

Did an part of your body strike anything in the vehicle? ❑Yes ❑No If Yes, please describe:
_____

_____

Make & Model of the vehicle you were occupying? _____

What was the approximate speed of your vehicle? _____

Did the impact to your vehicle come from the: ❑Front ❑Rear ❑Right side ❑Left side ❑Other _____

During impact, were you facing ❑Right ❑Left ❑Other _____ Were you ❑Aware or ❑Surprised by impact?

If another vehicle was involved, what was the Make and Model of the other vehicle? _____

What was the approximate speed of the other vehicle? _____

In your words, please describe the accident: _____

_____

_____

_____

Did your accident cause you to lose consciousness? ❑Yes ❑No If Yes, for how long? _____

Have you gone to a Hospital or seen another Doctor? ❑Yes ❑No Were they an ❑M.D. ❑D.C. ❑D.O. ❑D.D.S.

When did you go? _____

How did you get there? _____

Name of Hospital and/or attending doctor?: _____

Describe any treatment you received: _____ Were X-Rays taken? ❑Yes ❑No

Was medication prescribed? ❑Yes ❑No Have you been able to work since this injury? ❑Yes ❑No

Are your work activities restricted as a result of this injury? ❑Yes ❑No

Auto Insurance Information

Your Auto Insurance Company's Name: _____ Claim #:_____

Address:_____City:_____ State:_____ Zip:_____

Phone#:_____Insured's SS#:_____Policy #:_____

Insured's Name: _____Their Relation to you: _____

The Other Vehicles Insurance Company's Name:_____

Address: _____ City:_____ State:_____ Zip:_____

Phone#:_____Policy#:_____ Insured's Name:_____

Have you retained an attorney: ❑Yes ❑No If Yes, Whom: _____

In no, Are you planning to consult an attorney ❑Yes ❑No

Account Info: Person ultimately responsible for this account

Name:_____

Their relation to You: _____

Address:_____City:_____ State:_____ Zip:_____

Driver's License Number: _____

Work Phone#: _____

Social Security #:_____-_____-_____