

Auto Injury Information

Accident Details

Name _____ Today's Date _____
Date of Accident _____ Time of Accident _____ AM PM
Were you working at the time of the accident? Yes No
Location of Accident _____
Describe how the accident happened in your own words: _____

What kind of vehicle hit yours? _____ What kind of vehicle were you in? _____
Were you the Driver Passenger Pedestrian
If passenger, were you sitting in the Front Right Rear Left Rear Other _____
Did your vehicle hit other vehicle(s)? Yes No Estimated speed of your vehicle at impact? _____ MPH
Was your vehicle hit by another vehicle(s)? Yes No Estimated speed of other vehicle at impact? _____ MPH
Were you wearing a seat belt? Yes No

Medical Treatment

Did you go to the hospital or see another doctor for your injuries? Yes No
Name of Hospital: _____ Attended by Dr. _____
Were you x-rayed at the hospital? Yes No
Were you admitted to the hospital? Yes No How long did you stay? _____
What was the diagnosis? _____
What treatment was rendered? _____
What recommendations were made? _____
List any other doctors you have seen as a result of your injuries:
Dr. _____ Phone: _____ Dr. _____ Phone: _____

Disability

Have you lost any time from work because of this accident? Yes No If yes, give days of disability: _____
Totally disabled from _____ to _____ Partially disabled from _____ to _____
Have you returned to work since the accident? Yes No

Insurance Information

VEHICLE YOU WERE IN	OTHER VEHICLE
Driver _____	Driver: _____
Insured: _____	Insured: _____
Address: _____	Address: _____
Phone: _____	Phone: _____
Auto Insurance Co.: _____	Auto Insurance Co.: _____
Ins. Co. Address: _____	Ins. Co. Address: _____
_____	_____
Adjuster: _____	Adjuster: _____
Phone: _____	Phone: _____
Fax: _____	Fax: _____
Claim #: _____	Claim #: _____
P.I.P. <input type="checkbox"/> Yes <input type="checkbox"/> No	
Name of Insurance Company responsible for injuries: _____	
Have you been contacted by an Insurance Adjuster or Company Representative regarding this claim? [] YES [] NO	
Do you have an attorney who has advised you in this case? [] YES [] NO	
Attorney Name: _____ Phone No: _____	

Patient's Signature: _____

Date: _____