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. ☐ Yes ☐ 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: _____