Motor Vehicle Accident Information

Name_____ Accident Date_____ Today's Date_____

Automobile Accident Insurance Information

Patient's Insurance Company

Company Name_____ Phone #_____

Address_____ Claim#_____

City/State/Zip_____ Policy#_____

Insured's Insurance Information (driver of car you were in-if not you)

Insured's Name (if other than you)_____ Phone #_____

Company Name_____ Claim #_____

Address_____ Policy#_____

City/State/Zip_____

Other Driver's Insurance Information (other driver's car)

Other Driver's Name_____ Phone#_____

Company Name_____ Policy #_____

Address_____

City/State/Zip_____

Do you have an attorney on this case? No Yes Who?_____

Address_____ Phone_____

Payment is due at the time of service, unless other arrangements have been made. Patients involved in litigation (lawsuits) or third party payment are ultimately responsible for payment of services.

MY SIGNATURE IS ACKNOWLEDGEMENT THAT I HAVE READ THE ABOVE AND AGREE TO ABIDE BY THE SAME.

Patient Signature_____ Date_____

Guardian Signature_____ Date_____

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History of Accident/Subjective Complaint

History of Occurrence

Date of Accident_____ Time_____ AM PM Were you alone in the car? NO YES

Were you the driver? YES NO, then who? _____

Passenger: ☐ front right ☐ front middle ☐ rear right ☐ rear middle ☐ rear left

Who owns the car? _____ ____ Year/Model of car: _____

Where was the accident? City_____ State _____ Street_____

Cross street_____ Direction of travel_____

Visibility at the time if accident? ☐ Poor ☐ Fair ☐ Good

Road conditions? ☐ Icy ☐ Rainy & wet ☐ Clear ☐ Dark

Your car: ☐ Hit another car ☐ Was hit in the: ☐ Right ☐ Left ☐ Rear ☐ Front ☐ Side

Type of accident:

☐ Head-on collision ☐ Broadside collision ☐ Rear-end collision ☐ Front impact, rear-ended car in front

☐ Non-collision (describe):_____

_____

_____

Other vehicles involved? NO YES, please list type(s):_____

Indicate & State how the Accident Happened (note the car you were in as "A")

_____

_____

_____

_____

_____

Did the police come to the accident scene? NO YES

Did an ambulance come to the accident scene? NO YES

Were you transported by ambulance to the hospital? NO YES, Which hospital? _____

What was the approximate damage done to the car you were in? $_____. Was it drivable? NO YES

How much damage was done to the other vehicle? $_____. Was it drivable? NO YES

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Impact/Seat Belt/Headrest/Speed

Seat belt use: Were you wearing a ☐ Lap belt ☐ Shoulder belt ☐ Both ☐ No belt worn

Were you prewarned that the accident was about to happen? NO YES

Did you brace for the impact? NO YES

Does your car have a headrest? NO YES

If yes, then what was the position of those headrests compared to your head before the accident?

☐ Top of headrest even with bottom of head ☐ Top of headrest even with top of head

☐ Top of headrest even with middle of neck

Was your car braking? NO YES Was your car moving at the time of accident? NO YES

If your car was moving, how fast would you estimate you were going? _____ MPH (estimate)

How fast was the other car traveling? _____ MPH(estimate) ☐ Don't know

Head/Body Position

Head/body position at the time of impact: ☐ Head turned left ☐ Head turned right ☐ Head looking back

☐ Head forward ☐ Body straight in sitting position

☐ Body rotated left ☐ Body rotated right

Position of right & left arms at the time of impact (i.e., on steering wheel): _____

Position of right & left feet at time of impact (i.e., on brake): _____

Did the impact cause your seat back to slip backward or break? NO YES

Describe in your own words what happened to you upon impact: _____

_____

_____

At the time of the accident, recall what parts of your head or body hit what parts on the inside of your car:

_____

_____

As a result of the accident, you were: ☐ Rendered unconscious ☐ Dazed, circumstances vague

☐ Shaken up, but could function

Could you move all of your body parts? YES NO, then which ones and why? _____

_____

Were you able to get out of the car and walk unaided? YES NO, then why? _____

_____

Did you get any bleeding cuts or bruises? NO YES, then describe: _____

_____

Please describe how you felt immediately after the accident (be specific): _____

_____

How did you feel later that day or night? _____

How did you feel in the following days? _____

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First Doctor/Hospital/Clinic Seen

Did you seek medical help immediately/soon after the accident? NO YES?

If yes who did you first get treatment from? _____ Date of 1st visit: _____

Were you examined? NO YES Were x-rays taken? NO YES

Were you given treatment? NO YES, then describe: _____

Date of last treatment: _____

Second Doctor/Hospital/Clinic Seen

Did you seek medical help immediately/soon after the accident? NO YES?

If yes who did you first get treatment from? _____ Date of 1st visit_____

Were you examined? NO YES Were x-rays taken? NO YES

Were you given treatment? NO YES, then describe: _____

Date of last treatment:_____

Third Doctor/Hospital/Clinic Seen

Did you seek medical help immediately/soon after the accident? NO YES

If yes who did you first get treatment from? _____ Date of 1st visit_____

Were you examined? NO YES Were x-rays taken? NO YES

Were you given treatment? NO YES, then describe: _____

Date of last treatment: _____

Activities of Daily Living

Do you notice any of your home activities that are different now than from before the accident?

NO YES, then please list as (be specific): _____

Those activities that you are now unable to do: _____

Those activities that are now painful to do: _____

Those activities that are now difficult to do: _____

Work Status History

Have you missed time from work? NO YES, then mark one of the following:

☐ Full-time off work ☐ Part-time off work ☐ Unable to work at all

Prior Similar Complaints

Did you have any physical complaints before the accident? NO YES, then please list: _____

_____

Is there anything else the doctor should know? _____

_____

_____

_____

_____

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