AUTO ACCIDENT FORM

Date: _____/_____/_____

Patient Name: _____ DOB: ____/____/_____

Date of Accident: _____/_____/_____ Time: _____ am / pm

Location of Accident: _____

Auto Injury

Were you: ☐Driver ☐Passenger ☐Pedestrian

Were you struck from: ☐Front ☐Back ☐Right Side ☐Left Side

Did your car strike the others involved? ☐Yes ☐No ☐Undetermined

Did the other car strike yours? ☐Yes ☐No ☐Undetermined

What was the position of your head? ☐Looking forward ☐Looking back ☐Turned Left/Right

Did you see the accident was about to happen? ☐Yes ☐No

Were you considered at fault for the accident? ☐Yes ☐No ☐Undetermined

As a result of the accident, were traffic citations issued to you? ☐Yes ☐No

Did you require post-accident hospitalization? ☐Yes ☐No

Have you lost any days of work? ☐Yes ☐No If yes, dates_____/_____/_____to _____/_____/_____

How did the injury occur? (Please Be Specific)

_____

_____

_____

CHECK SYMPTOMS YOU HAVE NOTICED SINCE THE ACCIDENT

☐Headache	☐Sleeping problems	☐Lights bother eyes	☐Diarrhea	☐Neck pain	☐Head too heavy
☐Feet cold	☐Loss of memory	☐Pins/needles in arms	☐Neck stiff	☐Ears ringing	☐Hands cold
☐Dizziness	☐Face flushed	☐Pins/needles in legs	☐Constipation	☐Back pain	☐Numbness in fingers
☐Tension	☐Upset stomach	☐Buzzing in ears	☐Nervousness	☐Cold sweats	☐Numbness in toes
☐Aggression	☐Shortness of breath	☐Loss of Balance	☐Fainting	☐Fever	☐Irritability
☐Fatigue	☐Loss of smell	☐Academic changes	☐Depression	☐Loss of taste	☐Ability to focus
☐Vision change	☐Personality change	☐Academic ability	☐Chest pain	☐Ability to focus	
☐Loss of hand/eye coordination		☐Uncontrollable emotions			

INSURANCE INFORMATION

Your health insurance company: _____

Your car insurance company: _____ Claim# _____

Do you have Medical Pay (Med-Pay)? ☐Yes ☐No ☐Unsure Amount of Med-Pay $_____

****Many people have this policy and are unaware. If you are not sure if you are covered by Med-Pay please Contact your insurance agent. ***

Have you seen other medical professionals for this accident? ☐Yes ☐No

Other party's name: _____

Other party's insurance company: _____ Claim# _____

Have you been contacted by an insurance adjustor regarding this claim? ☐Yes ☐No

If yes, Insurance company _____ Name of adjustor _____

Adjustor's phone # (_____) _____-_____ Fax # (_____) _____-_____

Do you have an attorney that has advised you in this case? ☐Yes ☐No

If yes, Attorney's firm _____ Attorney's name _____

Attorney's Address _____ Phone # (_____) _____-_____

Street City State ZIP

Signature_____