Vehicle Accident Information

Patient Information

Date_____

Patient Name_____

Date of Accident _____ Time of Accident _____ ☐ am ☐ pm

Was the accident reported? _____

Name of Insurance Company *(of the car that you were in at time of accident)*?

_____ Claim # _____

Adjuster's name _____ Phone # _____

Have you received PIP apps? ☐Yes ☐No Completed? ☐Yes ☐No

Have they been returned to Insurance Company? ☐Yes ☐No

Attorney ☐Yes ☐No Attorney Name _____

Address_____City_____State _____ Zip _____

Phone # _____

Please describe the accident in your own words:

_____

_____

_____

Were you the: ☐Driver ☐Front Passenger ☐Rear Passenger ☐Pedestrian

How many vehicles were in the accident? _____

How many people were in the accident? _____

Were you unconscious after the accident? ☐Yes ☐No

Did you go to the hospital? ☐Yes ☐No

When did you go? ☐ Immediately ☐ Next Day ☐ 2 days or more after the accident

Did you stay overnight? ☐Yes ☐No

How did you get to the hospital? ☐Ambulance ☐Private Transportation ☐Other_____

Name of hospital? _____

Name of doctor? _____ Diagnosis?_____

What medication(s) were you prescribed?_____

What X-ray/MRI/Special Image(s) were taken_____

Treatment received (i.e. stitches, braces, etc.)_____

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Accident Details

Road/Street Name & City/State_____
Which direction were you headed_____
What speed you were traveling?_____ ☐ Unknown
Did your car impact another vehicle?☐Yes ☐No
Did your car impact a structure? ☐Yes ☐No
If yes,explain

_____
Did any part of your body strike anything in the vehicle? ☐Yes ☐ No
If yes, explain_____
Was impact from: ☐Front ☐Rear ☐Left ☐Right ☐Other_____
At the time of impact were you: ☐Looking straight ahead ☐Looking to the right
☐ Looking to the left ☐Looking down ☐Looking up
Was your torso:☐Forward ☐Left ☐Right ☐Flexed ☐Extended ☐ Other_____
Where were your hands positioned? ☐Both on the wheel ☐Right on the wheel
☐Left on the wheel ☐On the ceiling ☐On the dashboard ☐At your sides
Was your foot on the brake? ☐Yes ☐ No
If yes, which foot was on the brake? ☐Left ☐ Right
Were you: ☐Surprised by impact ☐Braced for impact
Was a police report filed? ☐ Yes ☐ No

YOUR VEHICLE

What type of vehicle were you in? ☐ Compact ☐ Mid-size ☐ SUV ☐ Truck
Was your car: ☐Slowing down ☐Stopped ☐Gaining speed ☐At a steady speed
Were you wearing seatbelts? ☐Yes ☐ No
If yes, what type? ☐ Lap ☐ Shoulder ☐ Both
Did you: ☐ Remain in your seatbelt ☐ Slide out of your seatbelt ☐ Partially slide out
What happened to your vehicle after the crash? (Ex: went straight, spun around, hit something)_____
What was damaged on/in your vehicle? (Be as descriptive as possible)_____
_____
Did the vehicle have airbags? ☐Yes ☐No Did they inflate properly? ☐Yes ☐No
Were the headrests:☐ Movable and fixed ☐ Non-movable and fixed ☐ No headrest
What was the position of the headrest? ☐ Low ☐ Mid-position ☐ High ☐ N/A

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Accident Details (con't)

OTHER VEHICLE

What type was the other vehicle? ☐ Compact ☐ Mid-size ☐ SUV ☐ Truck
Was your car: ☐Slowing down ☐Stopped ☐Gaining speed ☐At a steady speed
Which direction was the other vehicle headed? _____
What was their speed? _____ ☐ Unknown

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

_____ _____
Signature of patient, parent, guardian or representative Date

_____ _____
Print name of patient, parent, guardian, or representative Relationship to patient