Vehicle Accident – Patient Information

Patient Name: _____ Date of Birth: _____ Today's Date: _____

Date of Accident: _____

Name of Auto Insurance (of care you were in at the time of accident): _____

Claim Number: _____ Adjuster's Name: _____

Adjuster's Phone Number: _____

Have you received PIP apps: YES NO PIP apps completed: YES NO

Have they been returned to Insurance Company: YES NO

Attorney: YES NO Attorney Name: _____ Attorney Phone Number: _____

Attorney Office Address: _____

Please Describe the accident in your own words: _____

_____

_____

Which side of the vehicle was hit: _____ Number of vehicles involved: _____

Number of passengers in your car: _____ Number of passengers in other vehicle: _____

Type of vehicle that you were driving: _____ Other type of vehicle: _____

Weather conditions at the time of accident: _____ Time of Accident: _____

What was the speed you were travelling: _____

What role did you play in the accident: Driver Front Passenger Rear Passenger Pedestrian

Were seatbelts worn? _____ Did airbags deploy? _____ Were brakes applied at impact? _____

What direction was your body facing at impact?

Forward & Upright Turned to the left Turned to the right Bending forward

What was your head position at impact?

Facing forward Turned left Turned right Looking down Looking up Facing back seat

Were you aware of the impact? YES NO UNCERTAIN

Did any part of your body strike anything in the vehicle: YES NO

If yes, explain: _____

Did your car impact any structure? YES NO Did you lose consciousness? YES NO UNCERTAIN

What complaints did you have after the accident? _____

What complaints do you currently have? _____

Are you: Right handed Left handed Ambidextrous

Did you go to the hospital? YES NO

If yes, when did you go to the hospital?

Immediately Later in the day Next day More than 2 days after

Which hospital did you go to? _____

How did you get to the hospital? Drove yourself Ambulance Taxi/Uber Other

Did you have imaging performed? X-Rays MRI CT Scan Bone Scan None

Did you stay overnight? YES NO

Diagnosis: _____

Have any medications been prescribed? _____

Treatment received (stitches, braces, etc.): _____

Were police at the scene? YES, report was filed YES, report was not filed NO

Have you missed time from work due to this incident?

YES NO Not currently employed No, but I feel like I am unable to work

If yes to the above question, how much time fom work was missed? _____

Do you have any restrictions with you normal daily activies? _____