Automobile Accident Form

File #:_____ Date:_____

Patient Name:_____ Date of accident:_____

Please explain how your accident happened in detail:_____

_____

_____

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_____

Driver of other vehicle:_____

Other driver's insurance company name, address and phone #:_____

_____

Policy #:_____ Claim #:_____

Person who has contacted you from other driver's insurance co.:_____

Name of driver of vehicle you were in during accident:_____

Insurance company name, address and phone #:_____

_____

Policy #:_____ Claim #:_____

Person who has contacted you from insurance co.:_____

If you have an attorney, please give name, address and phone #:_____

_____

_____

Did you go to the emergency room after this accident: Yes____ No____

Have you seen any other doctor(s) for this accident: Yes____ No____

Doctor's name and address:_____

How often did you see this doctor:_____

How long did you see this doctor:_____

Have you ever had any complaints in the involved area before: Yes____ No_____

If yes, what were previous symptoms:_____

Immediately after the accident did you feel pain? If so where:_____

If no, when did you first feel pain:_____

Did your head strike the windshield or any object:_____

Were you knocked unconscious: Yes____ No____ If yes, how long:_____

What part of the car was struck:_____

Where were you inside the vehicle:_____

How many people were in your vehicle:_____

Have your activities at work been restricted as a result of this accident: Yes____ No:_____

Since your accident, are your symptoms: Getting worse____ The same____ Improving____