Personal Injury Information

Patient: _____ Today's Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Patient's Auto Insurance Company: _____ Policy: _____

Claims Address: _____

City: _____ State: _____ Zip: _____

Adjuster's Name: _____ Adjuster's Phone: _____

Name of Attorney: _____ Phone: _____

Attorney's Address: _____ City: _____ State: _____ Zip: _____

Driver of Other Vehicle: _____ Address if Known: _____

Insurance Co.: _____ Policy or Claim No.: _____

Claims Address: _____

City: _____ State: _____ Zip: _____

Adjuster's Name: _____ Adjuster's Phone: _____

ACCIDENT DETAILS: Please answer questions on reverse side also.

1. Date of Accident: _____ Time of Day: _____ Road Conditions: _____
2. Were you: ( ) Driver ( ) Passenger ( ) Front Seat ( ) Back Seat ( ) Left Side ( ) Right Side
3. Number of people in your vehicle: _____ Other vehicle: _____
4. City, State & County where accident occurred: _____
5. What direction were you headed? ( ) North ( ) South ( ) East ( ) West
6. What direction was other vehicle headed? ( ) North ( ) South ( ) East ( ) West
7. From what direction were you struck? ( ) Behind ( ) Front ( ) Left Side ( ) Right Side
8. Were you knocked unconscious? ( ) Yes ( ) No If Yes, for how long? _____
9. Were police notified? ( ) Yes ( ) No (Please give receptionist copy of accident report).
10. Describe the accident: _____

_____

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Personal Injury Information - Continued

11. Did you have any physical complaints BEFORE the accident? ❒ Yes ❒ No

    Describe: _____

12. What are your present complaints which you attribute to the accident? _____

    _____

13. Have you ever been involved in an accident before? ❒ Yes ❒ No If yes, describe the accident, including date, as well as injuries received: _____

    _____

14. Were you taken to a hospital for this present accident? ❒ Yes ❒ No

    Name & address of hospital: _____

15. Have you been treated by another doctor since the accident? ❒ Yes ❒ No

    Name & address of Doctor: _____

    What type of treatment did you receive? _____

16. Since this accident, are your symptoms: ( ) Getting worse ( ) Improving ( ) About the same

17. Have you lost time from work as a result of this accident? ❒ Yes ❒ No

    If yes, give last date worked: _____ Type of employment: _____

    Present salary: _____ Comments: _____

    Are you being compensated for time lost from work? ❒ Yes ❒ No Type of Compensation: _____

18. What activity restrictions do you notice as a result of this accident? _____

    _____

    _____

19. Other pertinent information or comments: _____

    _____

20. Signature of Patient: _____ Date: _____