

AUTO ACCIDENT INFORMATION AND REPORT

Patient Name:		Date:	ID # (For office use only)	
Policy Holder Name:		Insurance Company:		
Claim #:		Policy #:		
Adjuster:		Adjustor Phone #: ()		
Attorney Name:		Attorney Phone #: ()		
Attorney Address:		City:	State:	Zip:
Date of Accident: / /		What state did the accident occurred in?		Were you the driver? YES NO
Time of Accident: :		A.M. P.M.	Were you wearing your seatbelt? YES NO	
Were you:		Driver	Passenger (Front)	Passenger (Rear) Pedestrian
Type of Vehicle:		Auto	Truck Van Motorcycle	Motor home Bicycle
How the accident occurred:		Struck by another vehicle		Struck another vehicle
		Struck a stationary object		Other
Where was your vehicle hit?		Front Rear Right Side	Left Side	Right Front
		Left Front Right Rear	Left Rear	
Where was the other vehicle hit?		Front Rear Right Side	Left Side	Right Front
		Left Front Right Rear	Left Rear	
Did you receive any medical attention at the scene of the accident?		YES NO		
Were you rendered unconscious?		YES NO		
Where did you go immediately following the accident?		Hospital	Home	Personal Doctor
		To this office	Resumed Activity	
Were you: Shaken Disoriented				
Have you had any of the following: (check all that apply)				
X-Ray	Facility:	Date:	/	/
MRI	Facility:	Date:	/	/
CT Scan	Facility:	Date:	/	/
Other, Explain:	Facility:	Date:	/	/
Have you received any treatment for this injury?		YES	NO / If yes, please explain:	
Have you had any prior surgeries?		YES	NO / If yes, please explain:	
Have you had any prior accidents or injuries?		YES	NO / If yes, please explain:	
How did you feel immediately after the accident?				
In your own words please describe the accident?				

This form may be used in the determination of insurance benefits and/or litigation for compensation. It is imperative that this form be filled out completely to protect your rights of compensation.

Signature _____ **Date** / /