

Auto Injury Information

Name _____ Today's Date _____
Date of Accident _____ Time of Accident _____ AM PM
Location of Accident _____
Type of Accident: Auto/Traffic Work/On Job At Home Other _____
Describe how the accident happened in your own words: _____

Name of Hospital: _____ Attended by Dr. _____
Were you x-rayed at the hospital? Yes No If so, what was the diagnosis? _____
Were you admitted to the hospital? Yes No How long did you stay? _____
What treatment was rendered? _____
What recommendations were made? _____
List any other doctors you have seen as a result of this accident: _____

Have you lost any time from work because of this accident? Yes No
If yes, give days of disability: _____
Totally disabled from _____ to _____ Partially disabled from _____ to _____
Have you returned to work since the accident? Yes No Were you wearing a seat belt? Yes No
What kind of vehicle hit yours? _____ What kind of vehicle were you in? _____
If auto accident, were you the Driver Passenger Pedestrian?
If passenger, were you sitting in the Front Right Rear Left Rear Other _____
Did your vehicle hit other vehicle(s)? Yes No Estimated speed of your vehicle at impact? _____ MPH
Was your vehicle hit by another vehicle(s)? Yes No Estimated speed of other vehicle at impact? _____ MPH
Did your car strike the other(s) involved? Yes No or did the other car strike yours? Yes No
 Undetermined

VEHICLE YOU WERE IN:
Driver _____
Insured: _____
Address: _____
Phone: _____
Auto Insurance Co.: _____
Ins. Co. Address: _____
Adjuster: _____
Phone: _____
Policy #: _____
Claim # _____

OTHER VEHICLE
Driver: _____
Insured: _____
Address: _____
Phone: _____
Auto Insurance Co.: _____
Ins. Co. Address: _____
Adjuster: _____
Phone: _____
Policy #: _____
Claim # _____

Did you require post-accident hospitalization? Yes No

CHECK THE SYMPTOMS YOU HAVE NOTICED SINCE THE ACCIDENT:

- | | | | | |
|--|---|--|--|--|
| <input type="checkbox"/> Headache | <input type="checkbox"/> Irritability | <input type="checkbox"/> Numbness in toes | <input type="checkbox"/> Face flushed | <input type="checkbox"/> Feet cold |
| <input type="checkbox"/> Neck pain | <input type="checkbox"/> Chest pain | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Buzzing in ears | <input type="checkbox"/> Hands cold |
| <input type="checkbox"/> Neck stiff | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Loss of balance | <input type="checkbox"/> Stomach upset |
| <input type="checkbox"/> Sleeping problems | <input type="checkbox"/> Head seems too heavy | <input type="checkbox"/> Depression | <input type="checkbox"/> Fainting spells | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Back pain | <input type="checkbox"/> Pins & needles in Arms | <input type="checkbox"/> Light bothers eyes | <input type="checkbox"/> Loss of smell | <input type="checkbox"/> Cold sweats |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Pins & needles in Legs | <input type="checkbox"/> Loss of memory | <input type="checkbox"/> Loss of taste | <input type="checkbox"/> Fever |
| <input type="checkbox"/> Tension | <input type="checkbox"/> Numbness in fingers | <input type="checkbox"/> Ears ring | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> _____ |

Symptoms other than above: _____

Name of your Insurance Company involved: _____

Name of person at your Insurance Company responsible for injuries: _____

Have you been contacted by an Insurance Adjuster or Company Representative regarding this claim? YES NO

Do you have an attorney who has advised you in this case? YES NO Name: _____

Address of Attorney: _____ Phone No: _____

Patient's Signature: _____ Date: _____