



## AUTO ACCIDENT FORM

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

Date of Accident: \_\_\_\_/\_\_\_\_/\_\_\_\_ Time: \_\_\_\_\_ am / pm

Location of Accident: \_\_\_\_\_

### Auto Injury

Were you: ☐ Driver ☐ Passenger ☐ Pedestrian

Were you struck from: ☐ Front ☐ Back ☐ Right Side ☐ Left Side

Did your car strike the others involved? ☐ Yes ☐ No ☐ Undetermined

Did the other car strike yours? ☐ Yes ☐ No ☐ Undetermined

What was the position of your head? ☐ Looking forward ☐ Looking back ☐ Turned Left/Right

Did you see the accident was about to happen? ☐ Yes ☐ No

Were you considered at fault for the accident? ☐ Yes ☐ No ☐ Undetermined

As a result of the accident, were traffic citations issued to you? ☐ Yes ☐ No

Did you require post-accident hospitalization? ☐ Yes ☐ No

Have you lost any days of work? ☐ Yes ☐ No If yes, dates \_\_\_\_/\_\_\_\_/\_\_\_\_ to \_\_\_\_/\_\_\_\_/\_\_\_\_

How did the injury occur? (Please Be Specific)

### CHECK SYMPTOMS YOU HAVE NOTICED SINCE THE ACCIDENT

- |  |  |   |                                       |   |  |
|--|--|---|---------------------------------------|---|--|
| <input type="checkbox"/> Headache                      | <input type="checkbox"/> Sleeping problems       | <input type="checkbox"/> Lights bother eyes   | <input type="checkbox"/> Diarrhea     | <input type="checkbox"/> Neck pain        | <input type="checkbox"/> Head too heavy      |
| <input type="checkbox"/> Feet cold                     | <input type="checkbox"/> Loss of memory          | <input type="checkbox"/> Pins/needles in arms | <input type="checkbox"/> Neck stiff   | <input type="checkbox"/> Ears ringing     | <input type="checkbox"/> Hands cold          |
| <input type="checkbox"/> Dizziness                     | <input type="checkbox"/> Face flushed            | <input type="checkbox"/> Pins/needles in legs | <input type="checkbox"/> Constipation | <input type="checkbox"/> Back pain        | <input type="checkbox"/> Numbness in fingers |
| <input type="checkbox"/> Tension                       | <input type="checkbox"/> Upset stomach           | <input type="checkbox"/> Buzzing in ears      | <input type="checkbox"/> Nervousness  | <input type="checkbox"/> Cold sweats      | <input type="checkbox"/> Numbness in toes    |
| <input type="checkbox"/> Aggression                    | <input type="checkbox"/> Shortness of breath     | <input type="checkbox"/> Loss of Balance      | <input type="checkbox"/> Fainting     | <input type="checkbox"/> Fever            | <input type="checkbox"/> Irritability        |
| <input type="checkbox"/> Fatigue                       | <input type="checkbox"/> Loss of smell           | <input type="checkbox"/> Academic changes     | <input type="checkbox"/> Depression   | <input type="checkbox"/> Loss of taste    | <input type="checkbox"/> Ability to focus    |
| <input type="checkbox"/> Vision change                 | <input type="checkbox"/> Personality change      | <input type="checkbox"/> Academic ability     | <input type="checkbox"/> Chest pain   | <input type="checkbox"/> Ability to focus |  |
| <input type="checkbox"/> Loss of hand/eye coordination | <input type="checkbox"/> Uncontrollable emotions |   |                                       |   |  |

### INSURANCE INFORMATION

Your health insurance company: \_\_\_\_\_

Your car insurance company: \_\_\_\_\_ Claim# \_\_\_\_\_

Do you have Medical Pay (Med-Pay)? ☐ Yes ☐ No ☐ Unsure Amount of Med-Pay \$ \_\_\_\_\_

\*\*\*\*Many people have this policy and are unaware. If you are not sure if you are covered by Med-Pay please

Contact your insurance agent. \*\*\*

Have you seen other medical professionals for this accident? ☐ Yes ☐ No

Other party's name: \_\_\_\_\_

Other party's insurance company: \_\_\_\_\_ Claim# \_\_\_\_\_

Have you been contacted by an insurance adjustor regarding this claim? ☐ Yes ☐ No

If yes, Insurance company \_\_\_\_\_ Name of adjustor \_\_\_\_\_

Adjustor's phone # (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Fax # (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Do you have an attorney that has advised you in this case? ☐ Yes ☐ No

If yes, Attorney's firm \_\_\_\_\_ Attorney's name \_\_\_\_\_

Attorney's Address \_\_\_\_\_ Phone # (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Street

City

State

ZIP