



Auto Accident Form Initials _____

Patient Name _____	Today's Date ____/____/____
Insurance Company: _____	Claim Number: _____
Insurance Adjuster: _____	Phone Number of Adjuster: _____
Address to send Claims: _____	
Attorney Information:	
If you have an Attorney Involved, do we have permission to contact your attorney and/or share information regarding your medical care, including but not limited to progress notes and billing information pertaining to our facilities? <input type="checkbox"/> Yes <input type="checkbox"/> No _____	
Law Firm Name: _____	Attorney Name: _____
Phone Number: _____	Fax: _____
Address: _____	

Please mark your involvement in the Auto Accident: Pedestrian Driver Passenger

Is your Medical Insurance Primary? Yes No Is your claim in litigation? Yes No

Date of Accident ____/____/____ Any additional accidents? _____

Police Report: Yes No (If yes, please provide the office with a copy)

First Vehicle Type: Compact Mid-size Full-Size SUV Pick-up Motorcycle

How fast were you and/or the other vehicle traveling? _____

What side of your vehicle was hit? _____

Whose vehicle was it? _____ Were you the driver or passenger? _____

Second Vehicle Type: Compact Mid-size Full-Size SUV Pick-up Motorcycle

Were you wearing a seatbelt? Yes No Did your airbag deploy? Yes No

Accident Details

Accident Description _____

What were your injuries? _____ Initials _____

Hospitalized

Were you hospitalized? Yes No. If yes, please answer the questions below.

What hospital did you go to? _____

When were you hospitalized? Immediately Later the Same Day Next Day Date _____

How were you transported to the hospital? Ambulance Life Flight Private Transportation

What did the hospital recommend? No Instructions See this Clinic

See Own Doctor See Orthopedic Specialist See Neurologist See Neurosurgeon Prescription Medication

Other: _____

Did you have any imaging taken? Yes No If yes, what areas? _____

Did you have imaging taken prior to your accident? Yes No

Have you seen a doctor before the accident for similar symptoms? If yes, please explain the symptoms and what doctor.

Patient Signature: _____ Date: _____