



# Auto Accident Form Initials \_\_\_\_\_

Patient Name _____	Today's Date ____/____/____
Insurance Company: _____	Claim Number: _____
Insurance Adjuster: _____	Phone Number of Adjuster: _____
Address to send Claims: _____	
<b>Attorney Information:</b>	
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: \_\_\_\_\_