ACCIDENT/INJURY QUESTIONNAIRE

Name: (Last, First MI)_____ **Today's Date:** _____

AUTOMOBILE ACCIDENT – ADDITIONAL INFORMATION

- **Was anyone else in the vehicle with you?** ☐ **No** ☐ **Yes -** *(Number of people)* _____
- **Sitting Front seat:** ☐ *Driver* ☐ *Passenger* **Rear Seat**: ☐ Behind Driver ☐ Middle ☐ Behind Passenger ☐ 2nd Row ☐ 3rd Row
- **Name of Driver**, *if not self*: _____ **Name of Driver of other vehicle:** _____
- **Did airbags deploy?** ☐ **No** ☐ **Yes** **Did Police arrive?** ☐ **No** ☐ **Yes** **Using Seatbelt?** ☐ **No** ☐ **Yes**
- **Did you strike the windshield or object in car?** ☐ **No** ☐ **Yes** - *(Describe)* _____
- **Were you knocked unconscious?** ☐ **No** ☐ **Yes** *(How long?)* _____
- **Where was your vehicle impacted?** ☐ Front ☐ Rear ☐ Passenger Side ☐ Driver's Side ☐ Other: _____

Was the other driver at fault for the injury? If Yes, enter their claim information below:

Their Auto Ins: _____ **Policy #:** _____ **Claim #:** _____ **Phone #** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Most patients carry a policy called "Med-Pay" on their policy to help cover medical expenses. We will verify if your insurance will also help (if you were not at fault, it should not affect your rates to do this). Please enter your insurance information below and include the claim # if you've already filed a Med-Pay claim.

Your Auto Ins: _____ **Policy #:** _____ **Claim #:** _____ **Phone #:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

GENERAL ACCIDENT/INJURY INFORMATION – (*PLEASE USE THE REVERSE SIDE OF THIS PAGE IF ADDITIONAL SPACE IS NEEDED*)

Date of Accident: ___/___/___ **Time**: ___:___ AM / PM

Please describe the accident in as much detail as possible? _____

_____

_____

_____

At the time of the accident/injury:

- **Did you feel pain immediately after the accident?** ☐ **No** ☐ **Yes** ☐ **Later that day** ☐ **Next day** ☐ **When?** _____
- **Were you taken anywhere after the accident?** ☐ **No** ☐ **Yes** ☐ **Later that day** ☐ **Next day** ☐ **When?** _____
  - *If yes,* **How?** _____ **Where?** _____
  - *If yes,* **Did you receive treatment?** ☐ **No** ☐ **Yes -** *(Describe)* _____

Since the accident/injury:

- **Are your symptoms:** ☐ **Improving?** ☐ **Getting Worse?** ☐ **The Same?**
- **Are your work activities restricted as a result of this accident/injury?** ☐ **No** ☐ **Yes -** *(How?)* _____
- **Have you missed any work since this accident?** ☐ **No** ☐ **Yes -** *(Dates?)* _____
- **Have you retained an Attorney?** ☐ **No** ☐ **Yes - Name:** _____ **Phone:** _____
  - **Address:** _____ **City:** _____ **State:** _____ **Zip:** _____