Automobile Accident History (page 1)

Date: _____________

Patient Name: ______________________________ Date of Birth: _______________
Date of Accident: ___________________________ Time Accident Occurred: _____AM/PM
Were you taken to the hospital? Yes No Which Hospital? ___________________________
Were you required to stay in the hospital as a patient? Yes No
What is the name of the doctor that treated you after the accident? _________________________
If you were seen in a hospital/clinic, were x-rays taken at that time? Yes No
If YES, what X-rays were taken? Head Shoulders Neck Back Arm(s) Leg(s) Pelvis Feet Hand(s)
Have you retained an attorney? Yes No His/Her name:______________________________
The following questions pertain to you, the patient, and the vehicle you were in:

- What type of accident was this? Please Circle one:
  - Head-on (hood to hood)
  - Hit in rear (rear-ended)
  - Side Swiped (changing lanes, side to side of cars)
  - T-Boned (hood impacted side of car)
  - Other _____________________________________
- Where were you seated in the vehicle? ____
- Was the trunk of your body pointed straight-forward at the time of impact? ________________
- If no, which direction was it turned, and how much? ____________________________________
- Was your head pointed straight-forward at the time of impact? ____________________________
- If no, which direction was it turned, and how much? ____________________________________
- What were you doing at the time of impact? ____
- Were you aware of the approaching collision prior to impact or did it catch you by surprise?

____

- Did you lose consciousness? Yes No If yes, for approximately how long? ____________
- Was anyone else in your car injured in the accident? ____________________________________
- How far is the top of the headrest from the top of your head?
  - Approximately________inches above or below (circle one)
- Were you wearing a seatbelt? Yes No Type: Lap Shoulder-Lap
- Were airbags engaged? Yes No

Automobile Accident History (page 2)

Patient Name: ________________________________

- What is the Year________, Make________, Model________ of the car you were in?
- Was your car stopped at the time of impact? Yes No
- Was the driver's foot on the brake? Yes No
- If the car you were in was moving, estimate the speed of the vehicle at the time of the accident:_________________
- Was the car: (Circle One) Slowing down Gaining speed Steady rate
- Which body parts had contact with any part of the vehicle at the time of impact?

Please list which part of the vehicle the body had contact with. (examples: seatbelt, steering wheel, headrest. window, windshield, armrest, etc.)

1. Head ____
2. Neck________________________________(right or left side)
3. Chest ____
4. Shoulder_____________________________(right or left)
5. Arm_________________________________(right or left)
6. Upper Back______________________(right, middle, or left side)
7. Lower Back______________________(right, middle, or left side)
8. Hip_________________________________(right or left)
9. Leg_________________________________(right or left)
10. Other (Examples: HAND, WRIST, ELBOW, FOOT) ______________________________________

- What type of clothing/fabric were you wearing at the time of the accident? _________________
- What type of fabric is the car seat made of ?____
- What is the cost of damage to the vehicle you were in? ____________________________________
- Which of the following car parts broke during the accident?:

_____ Windshield
_____ Side Window (right or left) (front or back)
_____ Steering Wheel
_____ Seats (right or left) (front or back)
_____ Doors (right or left) (front or back)
_____ Bumpers (front or back)
_____ Other____________________
_____ None

- Were you on the job at the time of injury? Yes No
- Were you unable to work due to injuries sustained? Yes No If Yes, How long?______________
- What day did you return to work?_________________Full-time Part-time
- Any restrictions? ____
- What symptoms were you experiencing prior to this accident? _____________________________

____

The following questions pertain to the other vehicle involved in the accident:

- What is the Year_________, Make_________, Model________ of the other car?
- Was the other car moving at the time of impact? Yes No
- Estimate the speed of the other vehicle:______________________________
- Was the other driver or any passengers injured in this accident? Yes No Unknown

Automobile Accident Insurance Information (Page 3)

Patient Name: ___________________________________Date:___________________

1. Date of accident ____________________________
2. Who was issued at fault? You ___ Other Party____

Please give us your automobile insurance information or driver of vehicle, if you were a passenger:
Name of automobile insurance company ____
Claims Mailing Address ____
Claim # ____Claims Phone #______________________
Name of Claims Adjuster _______________________________Phone #_______________________
Claims Adjuster's email address:____
Name of insured (if different from the patient) ____
Do you carry "Med Pay or PIP Coverage"? Yes ___ No ___ Amount _____
Do you carry uninsured coverage on your policy? Yes ___ No ___

Please give us the other involved parties' automobile insurance information:
Name of other driver or primary policy holder ____
Name of other automobile insurance company ____
Claim's mailing Address ____
Claim # __________________________________Claims Phone #____________________________
Name of Claims Adjuster _______________________________Phone #_______________________
Claims Adjuster's email address:____

- If you carry personal "Med Pay" or PIP coverage: Your insurance is primary, regardless of who is at fault. You will need to sign/fill out/send back to the insurance company: Assignment of benefits,
Med Pay authorization letter, medical records request (suggest changes to protect the patient)
- You are responsible for obtaining your claim #, and signing all needed forms to get your claims processed. ie: Assignment of benefits, Med Pay authorization letter, medical records request (suggest changes to protect the patient)
- Your premiums CAN NOT go up for utilizing benefits you purchased. They may, however, go up if you were deemed "at fault"; regardless of if you use your Med Pay.

Please attach copy of the automobile accident report

Patient Description of Automobile Accident (Page 4)

Patient Name:________________________________ Date:_____________

Explain in your own words exactly how this accident occurred; what you felt as it happened, and how you have felt since. It is important that you describe all activities related to this accident including any emergency help such as paramedics, police, bystanders, etc., that may have assisted. Please be as detailed and specific as possible. No fact is too small to mention.
*If you need more space, feel free to continue writing on the back or attach another document.

____

____

____

____

____

____

____

____

____

____

____

____

____

____

____

____

____

____

____

____

____

____

____

____