

ACCIDENT REPORT

Name: _____ Date: _____
Last First Middle

Insurance Information	My (auto/workman comp.) insurance is:	Claim #
	My personal insurance is:	
	Driver's name of other vehicle, if applicable:	
	Name of their insurance company?	

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

Attorney's Name: _____ Address: _____ Phone: _____

ACCIDENT INFORMATION

Date of Accident: _____ Hour: _____ AM PM

Accident Location: _____

How did the accident happen?

If Auto Accident	How many people were in the auto?	
	Were you the:	<input type="checkbox"/> Driver <input type="checkbox"/> Pedestrian <input type="checkbox"/> Passenger (Front Seat) <input type="checkbox"/> Passenger (Back Seat)
	Was your car struck from:	<input type="checkbox"/> Behind <input type="checkbox"/> Front <input type="checkbox"/> Left Side <input type="checkbox"/> Right Side
	Did your car strike the other(s) involved? Or	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Undetermined
	Did the other car strike yours?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Undetermined

INJURY INFORMATION

What happened to you at the time of impact?		
What did you feel immediately after the accident?		
When did you first notice symptoms from the accident?		
Where were you taken after the accident?		
What was done to you there?		
Did you require post-accident hospitalization?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Where?
List all the doctors and type of treatment since the accident.		
Have you lost any days from work?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, what kind of work and when?
Did you return to work?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, on what date?

Patient's signature: _____ Date: _____

If minor, parent's signature: _____ Date: _____