

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 Did the other car strike yours? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Undetermined |
| | | <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: _____