ACCIDENT INFORMATION

Please PRINT clearly.

Today's Date: _____

PATIENT INFORMATION

Name: (Last, First, MI) _____ **Preferred Name**: _____

ACCIDENT INFORMATION -- ***Please use back of this page if needed.***

Date of accident: _____ Time of Accident: _____ Number of people in accident vehicle: _____

Location/street of Accident:_____

Were you the: ☐ Driver ☐ Front Passenger ☐ Rear Passenger -- Behind Driver / Middle / Behind Passenger / 2nd Row / 3rd Row

Name of Driver, *if not you* _____ Name of Driver of other Vehicle: _____

Make/Model of Vehicle you were in: _____

Is vehicle equipped with airbags? ☐ Yes ☐ No Did airbags inflate? ☐ Yes ☐ No Were you wearing a seatbelt? ☐ Yes ☐ No

Where did the impact come from? ☐ Front ☐ Rear ☐ Driver side ☐ Passenger Side

In relation to the base of your skull, where was the headrest? ☐ Above ☐ Below ☐ At the base

In what direction were you headed? ☐ North ☐ South ☐ East ☐ West

In what direction was the other vehicle headed? ☐ North ☐ South ☐ East ☐ West

During impact were you facing: ☐ Forward ☐ Backward ☐ Right ☐ Left

Did any part of your body strike anything in the vehicle? ☐ Yes ☐ No (Describe):_____

_____

Were you rendered unconscious? ☐ Yes ☐ No If yes, for how long? _____

What was the approximate speed of your vehicle? _____ The other vehicle? _____

Were you ☐ Aware ☐ Surprised by the impact? What did your vehicle impact? ☐ Another vehicle ☐ Other:_____

Please list the name of the other victims in the accident, if any:_____

_____

In your own words please describe the accident in detail: _____

_____

_____

_____

INSURANCE INFORMATION

Your Auto Ins: _____Policy #_____ Claim#_____ Phone#_____

Address:_____

Other's Auto Ins:_____Policy #_____ Claim#_____ Phone#_____

Address:_____

MEDICAL INFORMATION

BEFORE THE ACCIDENT:

Have you had complaints in the involved area? ☐ Yes ☐ No

Were they present at the time of the accident? ☐ Yes ☐ No

Describe: _____

Were you able to work without restrictions before the accident? ☐ Yes ☐ No

AT THE TIME OF THE ACCIDENT:

Did you feel pain immediately after the accident? ☐ Yes ☐ No ☐ Later that Day ☐ Next Day ☐ When? _____

Did you go to a hospital or seen any other doctor? ☐ Yes ☐ No When did you go? ☐ Immediately ☐ Next Day ☐ Other_____

How did you get there? ☐ Ambulance ☐ Private Transportation Was medication prescribed? ☐ Yes ☐ No

Describe the treatment you received: _____

Name of hospital and/or attending doctor:_____

Was he/she a : ☐ DDS ☐ MD ☐ DC ☐ DO Were any x-rays taken? ☐ Yes ☐ No

SINCE THE ACCIDENT:

Are your symptoms: ☐ getting better ☐ getting worse ☐ staying the same

Have you been able to work since this injury? ☐ Yes ☐ No

Are your work activities restricted as a result of this injury? ☐ Yes ☐ No

LEGAL INFORMATION

Did the police come to the scene of the accident? ☐ Yes ☐ No Was a police report filed? ☐ Yes ☐ No

Were there any witnesses? ☐ Yes ☐ No Was a traffic violation issued? ☐ Yes ☐ No To whom? _____

Have you retained an attorney? ☐ Yes ☐ No If yes, whom? _____Phone:_____

Patient/Guardian Signature:_____ Date: _____