VEHICLE ACCIDENT INFORMATION

PATIENT INFORMATION

Date: _____

Patient Name: _____

Date of Accident: _____ Time of Accident: _____ ☐ a.m. ☐ p.m.

Please describe the accident in your own words: _____

_____

_____

_____

Were you the: ☐ Driver ☐ Front Passenger ☐ Rear Passenger ☐ Pedestrian

How many people were in the vehicle? _____

ACCIDENT SITE

Road/Street Name: _____

City/State: _____

Nearest intersection with road/street _____

Driving conditions ☐ Dry ☐ Wet ☐ Icy ☐ Other

Which direction were you headed? _____

Speed you were traveling? _____

VEHICLE

Make and model of vehicle you were in:

_____

Were you wearing a seat belt? ☐ Yes ☐ No

If yes, what type ☐ Lap ☐ Shoulder

Was vehicle equipped with airbags? ☐ Yes ☐ No

If yes, did it/they inflate properly? ☐ Yes ☐ No

Did your seat have a headrest? ☐ Yes ☐ No

If yes, what was the position of the headrest?

☐ Low ☐ Midposition ☐ High

IMPACT

Did your car impact another vehicle? ☐ Yes ☐ No

Did you car impact a structure? ☐ Yes ☐ No

If yes, explain _____

_____

Did any part of your body strike anything in the vehicle?

☐ Yes ☐ No If yes, explain _____

Was impact from:

☐Front ☐Rear ☐Left ☐Right ☐Other_____

At the time of impact were you:

☐Looking straight ahead ☐Looking to the right

☐Looking to the left ☐Looking down

☐Looking up

Were both hands on the steering wheel? ☐Yes ☐No

If no,which hand was on the wheel? ☐Right ☐Left

Was your foot on the brake? ☐Yes ☐No

If no,which foot was on the wheel? ☐Right ☐Left

Were you: ☐ Surprised by impact ☐ Braced for impact

OTHER VEHICLE

Make and model of other vehicle_____

Which direction was the other vehicle headed?

_____

Speed other vehicle was traveling_____

POLICE

Did the police come to the accident site?☐ Yes ☐ No

Were there any witnesses? ☐ Yes ☐ No

Was a police report filed? ☐ Yes ☐ No

Was a traffic violation issued? ☐ Yes ☐ No

If yes, to whom? _____

PATIENT CONDITION

Were you unconscious immediately after the accident? ☐ Yes ☐ No If yes, for how long?_____

Please describe how you felt immediately after the accident:

_____

_____

_____

TREATMENT

Did you go to the hospital? ☐ Yes ☐ No

When did you go? ☐ Immediately after accident ☐ Next day ☐ 2 days or more after the accident

How did you get to the hospital? ☐ Ambulance ☐ Private transportation

Name of hospital:_____ Name of Doctor_____

Diagnosis:_____

_____

Treatment received:_____

X-rays taken:_____

SYMPTOMS / INJURIES

Have you been able to work since this injury? ☐ Yes ☐ No How many work days have you missed?_____

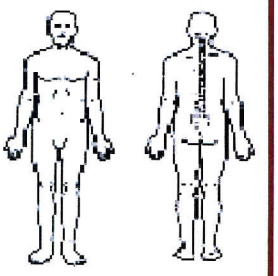
Prior to the injury were you able to work on an equal basis with others your age? ☐ Yes ☐ No

If you have had any of the following symptoms since your injury, please check appropriate box.

☐ Arm / shoulder pain	☐ Feet / toe numbness	☐ Neck pain
☐ Back pain	☐ Hand / finger numbness	☐ Neck stiff
☐ Back stiffness	☐ Headaches	☐ Shortness of breath
☐ Chest pain	☐ Irritability	☐ Sleep difficulty
☐ Dizziness	☐ Jaw problems	☐ Stomach upset
☐ Ear buzzing	☐ Leg pain	☐ Tension
☐ Ear ringing	☐ Memory loss	☐ Vision blurred
☐ Fatigue	☐ Nausea	

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

Mark an X on the picture where you continue to have pain, numbness or tingling.



Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

Type of pain:

☐ Sharp	☐ Dull	☐ Throbbing	☐ Numbness
☐ Aching	☐ Shooting	☐ Burning	☐ Tingling
☐ Cramps	☐ Stiffness	☐ Swelling	☐ Other _____

How often do you have this pain? _____

Is it constant or does it come and go? _____

Does it interfere with your: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Movements that are painful to perform: ☐ Sitting ☐ Walking ☐ Standing ☐ Bending ☐ Lying Down

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

_____ _____

Signature of Patient, Guardian or Personal Representative Date

_____ _____

Please print name of Patient, Guardian or Personal Representative Relationship to Patient

Please Provide the Following Information

Patient Information:

Name of Auto Insurance Co._____

Insurance Co phone #:_____

Claim # :_____

Claim Adjuster's Name:_____

Claims Address:_____

_____

At Fault Party:

Name:_____

Name of Insurance Co.:_____

Phone # of Insurance Co.:_____

Claim#:_____

Claim Adjuster's Name:_____

Claims Address:_____

_____

Other Information

Do you have an attorney? _____

If yes, please provide name and phone#:_____

_____

Do you have health insurance? If so, name of Insurance Co.:_____

Please provide us with a copy of your health insurance card.

Information to open MedPay Claim:*

Your Insurance Company : _____

Insurance Telephone # : _____

Claim Number : _____

Claim Adjuster : _____

Claim Address : _____

_____

Please contact your insurance company and request them to open a Medical Payments Claim.

***MedPay is payment for medical treatments (Emergency room, family doctor, chiropractor, MRI's, etc.) rendered as a result of an auto accident. Your personal auto insurance pays your medical bills and keeps a running tab of the amount paid. When your case settles, your insurance company is reimbursed by the insurance company of the at-fault driver. MedPay is something that you have and something that you pay for as part of your policy. Using MedPay does not make your rates go up and will not make your auto insurance drop your policy.**

As a courtesy to you, the Assignment forms you signed give our office your consent to submit the necessary medical records as well as consent for our office to bill the insurance company directly. You do not need to do anything other than contact your auto insurance company, open a MedPay claim and provide our office with the above requested information.

Please feel free to ask any questions should you need any additional information.

Thank You.