Personal Injury Information

Patient: ____ Today's Date: __________________
Address: ____
City: _____________________________________ State: ____________ Zip: _________________

Patient's Auto Insurance Company: _________________________ Claim #:_________________
Claims Address: ____
City: _____________________________________ State: ____________ Zip: _________________
Adjuster's Name: _____________________________________ Phone #: ____________________
Name of Attorney: _____________________________________ Phone #: ___________________
Attorney's Address: ____
City: _____________________________________ State: ____________ Zip: _________________

Driver of Other Vehicle: _________________________ Address:___________________________
Insurance Co.: ______________________________ Policy or Claim #:_______________________
Claims Address: ____
City: ______________________________________ State: ____________ Zip: ________________
Adjuster's Name: ____________________________________ Phone #: ______________________

Accident Details: Please answer questions on reverse side also.

1. Date of Accident:____________ Time of Day: ____________ Road Conditions:____________
2. Were you: ( ) Driver ( ) Passenger ( ) Front Seat ( ) Back Seat ( ) Left Side ( ) Right Side
3. Number of people in your vehicle:___________________ Other Vehicle: __________________
4. City, State & County where accident occurred: ____
5. What direction were you headed? ( ) North ( ) South ( ) East ( ) West
6. What direction was the other vehicle headed? ( ) North ( ) South ( ) East ( ) West
7. From what direction were you struck? ( ) Behind ( ) Front ( ) Left Side ( ) Right Side
8. Were you knocked unconscious? ( ) Yes ( ) No If yes, for how long? __________________
9. Were police notified? ( ) Yes ( ) No (Please give receptionist a copy of the accident report).
10. Describe the accident: ____

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11. Did you have any physical complaints BEFORE the accident? ( ) Yes ( ) No
    Describe: ____
12. What are your present complaints which you attribute to the accident? _____________________
    ____
13. Have you ever been involved in an accident before? ( ) Yes ( ) No If yes, describe the accident, including the date, as well as injuries received: ____
    ____

14. Were you taken to a hospital to this present accident? ( ) Yes ( ) No
    Name and address of hospital: ____
15. Have you been treated by another doctor since the accident? ( ) Yes ( ) No
    Name and address of doctor: ____
    What type of treatment did you receive? ____

16. Since this accident, are your symptoms: ( ) Getting worse ( ) Improving ( ) About the same
17. Have you lost time from work as a result of this accident? ( ) Yes ( ) No
    If yes, give last date worked: ________________ Type of employment: ___________________
    Present salary: _________________ Comments: ____
    Are you being compensated for time lost from work? ( ) Yes ( ) No
    Type of compensation: ____
18. What activity restrictions do you notice as a result of this accident? _______________________
    ____
    ____
19. Other pertinent information or comments: ____
    ____

20. Signature of Patient: ____________________________________ Date: ___________________