Automobile Accident History

Date: _______________
Patient Name: ________________________________Date of Birth:__________________
Date of Accident: ____________________Time Accident Occurred: ____AM/PM
Were you taken to the hospital? Yes No Which One? ___________________________
Were you required to stay in the hospital as a patient? Yes No
What is the name of the doctor that treated you after the accident?___________________
If you were seen in a hospital/clinic, were x-rays taken at that time? Yes No
If YES, what X-rays were taken? Head Shoulders Neck Back Arm(s) Leg(s)
Pelvis Feet Hand(s)

The following questions pertain to you, the patient, and the vehicle you were in:

- What type of accident was this? Please Circle one below:
  Head-on (hood to hood) **Hit in rear** **Side Swiped** (changing lanes, side to side of cars) **T-Boned** (hood impacted side of car)
- Where were you seated in the vehicle?______________________________________
- Was the trunk of your body pointed straightforward at the time of impact? _________
- If no, which direction was it turned, and how much?____________________________
- Was your head pointed straightforward at the time of impact? ___________________
- If no, which direction was it turned, and how much?____________________________
- What were you doing at the time of impact? __________________________________
- Were you aware of the approaching collision prior to impact or did it catch you by surprise? ____
- Did you lose consciousness? Yes No
- If yes for approximately how long? ______________
- Was anyone else in your car injured in the accident?____________________________
- How far is the top of the headrest or the car from the top of your head? Approximately_____________inches above or below (circle one)
- Were you wearing a seatbelt? Yes No Type: Lap Shoulder-Lap
- Were airbags engaged? Yes No

Patient Name: ________________________________

Patient Name: ______________________________

- What is the Year_________, Make_________, Model_________ of the car you were in?
- Was your car stopped at the time of impact? Yes No
- Was the driver's foot on the brake? Yes No
- If the car you were in was moving, estimate the speed of the vehicle at the time of the accident:____________________
- Was the car: (Circle One) Slowing down Gaining speed Steady rate
- Describe what happened to the following body parts at the time of impact:
    1. Head ____
    2. Neck_______________________________________(right or left)
    3. Chest ____
    4. Shoulder____________________________________(right or left)
    5. Arm____(right or left)
    6. Upper Back__________________________(right, middle, or left)
    7. Lower Back__________________________(right, middle, or left)
    8. Hip____(right or left)
    9. Leg____(right or left)
    10. Other ____
- What type of clothing were you wearing at the time of the accident? (Indicate type of material)____
- Were the vehicle seats leather or cloth?_____________________________________
- What is the cost of damage to the vehicle you were in?_________________________
- Which of the following car parts broke during the accident?:
    1. Windshield ____________
    2. Side Window (right or left) (front or back)
    3. Steering Wheel__________
    4. Seats (right or left) (front or back)
    5. Doors (right or left) (front or back)
    6. Bumpers (front or back)
    7. Other ____
    8. None
- Were you on the job at the time of injury? Yes No . Was a report filed with your employer? Y N
- Were you unable to work/ attend school due to injuries sustained? Yes No If yes, From:________ To: ___________
- Have you retained an attorney? If yes, His/Her name_____________________

The following questions pertain to the other vehicle involved in the accident:

- What is the Year__________, Make__________, Model_________ of the other car?
- Was the other car moving at the time of impact? Yes No
- Estimate the speed of the other vehicle: _____________________________________
- Was the other driver or any passengers injured in this accident?
  Yes No Unknown

Patient Description of Automobile Accident

Patient Name:______________________________________ Date:________________

Explain in your own words exactly how this accident occurred; what you felt as it happened, and how you have felt since. It is important that you describe all activities related to this accident including any emergency help such as paramedics, police, bystanders, etc., that may have assisted. Please use details and be specific, as no fact is too small to mention.

Automobile Accident Insurance Information

Patient Name: ____ Date: ________________

1. Date of accident __________________________________
2. Who was issued at fault? You ___ Other Party____

Please give us your automobile insurance information *or* driver of vehicle, if you were a passenger:

Name of automobile insurance company____
Claims Mailing Address ____
Claim # ______________________________ Claims Phone # ______________________

Name of insured **(if different from the patient)** _______________________________
Do you carry "Med Pay or PIP Coverage"? Yes No Amount ______
Do you carry uninsured coverage on your policy? Yes No
Have you accepted any settlement? Yes No
Has either insurance contacted you regarding settling your claim? Yes

Please give us other involved parties' automobile insurance information:

Name of other driver ____
Name of other automobile insurance company ____________________________________
Address ____
Claim # ____
Phone # ______________________________

- If you carry personal "Med Pay" or PIP coverage: **Your insurance is primary**, regardless of who is at fault. You must open a Med Pay claim.

- You are responsible for obtaining your claim #, and signing all needed forms to get your claims processed. ie: Assign of benefits, Med Pay authorization letter, medical records request (suggest changes to protect the patient)

- Your premiums CAN NOT go up for utilizing benefits you purchased. They may, however, go up if you were deemed "at fault"; regardless of if you use your Med Pay.

Please attach copy of the automobile accident report