AUTOMOBILE ACCIDENT INFORMATION

LAST:_____**FIRST:**_____**DATE:**_____

Policyholder of the car you were in during the accident:_____**DATE OF ACCIDENT:**_____

Relationship to the Policyholder:_____

Insurance Company:_____Claim#_____

Address:_____

Phone#:_____Fax #:_____

Claim Adjuster:_____Reported to Insurance Company? Yes / No

Have you contacted an Attorney? ___Yes ___No

Attorney's Name:_____Phone:_____

Address:_____

What was your position in the vehicle?

___Driver ___Front Passenger ___Left Rear Passenger ___Middle Front Passenger

___Left Rear Passenger ___Right Rear Passenger ___Right Rear Passenger

What was the damage to the vehicle? ___Mild ___Moderate ___Extensive ___Totaled

How was the visibility on the road? ___Poor ___Fair ___Good

How did the accident happen?

___You hit another vehicle ___Another vehicle hit you ___You hit another object

Make and Model of the Vehicle which hit you:_____

_____

_____

LAST:_____**FIRST:**_____**DATE:**_____

Where was the point of impact on your vehicle?

___Left ___Front End ___Rear End ___Right

___Left Front ___Left Rear ___Right Rear ___Right Rear

Did you see the accident coming? ___Yes ___No

Were you braced for the impact? ___Yes ___No

Were you wearing a seatbelt? ___Yes ___No

Did you airbag deploy during the accident? ___Yes ___No

Does the vehicle have headrests? ___Yes ___No

If yes, positioned: ___Even w/top of Head ___Even w/bottom of Head ___Middle of the Neck

Did you strike anything inside the vehicle? ___Yes ___No

What inside your vehicle did you strike? ___Wheel ___Windshield ___Arm Rest

___Side Door ___Side Window ___Airbag

Immediately after the accident, did you feel dazed? ___Yes ___No

Did you lose consciousness? ___Yes ___No

Which way was your head turned during the impact?

___Facing straight forward ___Turned to the right ___Turned to the Left

Did you see another doctor before coming here? ___Yes ___No

Did you go to a hospital after the accident? ___Yes ___No, If yes – which hospital?_____

How did you get to the hospital? ___Drove Self ___Ambulance ___Police ___ Somebody Else

Were any of the following tests performed at the hospital?

___XRAYS ___MRI ___CT Scan ___Lab Work

Have you lost time from work? ___Yes ___No

Can you go to sleep without problems? ___Yes ___No

Do you awaken because of the pain? ___Yes ___No

Did you have problems sleeping before? ___Yes ___No

SIGNATURE:_____**DATE:**_____