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 History

Today's 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
• 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

Patient Name: _____________________________

• 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? Yes / No
- 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

Automobile Accident Insurance Information

Patient Name: ___________________________________ Today's Date: ____________
Address: ____
City/State/Zip:____

COLLISION DETAILS:
Date of accident: _____________ At Fault: Patient / Other Party
Description of crash:____
____
Police Dept who came on scene: ____
Ticket Issued: Yes / No To Whom: Patient / Other Driver

INSURANCE INFORMATION:

Patient or Driver of Vehicle Auto Insurance Company: __________________________________
Name of Insured (if different from the patient): _______________________________________
Claim #: __________________________________
Adjuster Name: ______________________________ Phone #/Ext:________________________
Fax #: ____
Claims Address: ____
Med Pay or PIP Coverage on Policy: Yes / No Coverage Dollar Amount: $__________
Uninsured Motorist Coverage on your Policy: Yes / No
Have you accepted any settlement: Yes / No
Has either insurance contacted you regarding settling your claim: Yes / No Whom: ___________

At Fault Auto Insurance Company: ____
Name of Other Driver: ____
Claim #: ___________________________________
Adjuster Name: ______________________________ Phone #/Ext:________________________
Fax #: ____
Claims Address: ____

Attorney Information:
Attorney Name: ____ Phone: ____________________
Address: ____

- **Med Pay or PIP Coverage is primary regardless of who is at fault.**
- **You are responsible for obtaining the claim numbers and signing necessary forms to get your claim processed.**

- **Examples of forms: Assignment of Benefits, Med Pay Authorization Letter, Medical Records Request (update the date on the release for the date of the auto accident)**