

Motor Vehicle Crash Information

Your Name: _____ Today's Date: _____ Date of Crash _____

Please answer the following as it relates to your motor vehicle crash:

Where did you go after the incident? Home Work Hospital / Acute Care

If Hospital / Acute Care, which facility: _____

How did you get to the facility? Ambulance Private Transportation

Please fill-out the following as it relates to *your* vehicle information:

During the incident, you were the: Driver Front Seat Passenger

Rear Seat Passenger Other: _____

Vehicle Year: _____ Vehicle Make and Model: _____

Your estimated speed at the moment of impact: _____ MPH Accelerating Decelerating Stopped

Please fill-out the following as it relates to *the other* vehicle information:

Vehicle Year: _____ Vehicle Make and Model: _____

Their estimated speed at the moment of impact: _____ MPH Accelerating Decelerating Stopped

Please fill-out the following general information as it relates to your incident:

Time of Day: Dawn Daylight Dusk Night

Road Conditions: Dry Damp Wet Snowy Icy Loose Gravel Other: _____

Head Restraints: Up Down Unsure

Did your seat break? Yes No Was the seat altered by the impact? Yes No

Lap Belt: Wearing Not Wearing Shoulder Harness: Wearing Not Wearing

Were you aware of the impending collision? Yes No

Did the airbag deploy? Yes No Did the airbag strike you? Yes No

Hands: Two on wheel One on wheel Unsure

Body Position: Good Forward Lean Other: _____

Head Position: Forward Turned Left Turned Right Up Down

Were the brakes applied? Yes No

Did you strike any parts of the vehicle? Yes No

If yes, what struck you, and where? _____

Did the vehicle strike any object? Yes No

If yes, please describe: _____

Did you lose consciousness? Yes No

Were the police notified? Yes No If yes, was a police report made? Yes No

Estimated property damage to your vehicle: \$ _____

Estimated property damage to the other vehicle: None Minimal Moderate Major

Please describe the crash in your own words: _____

CAR/DRIVER'S INSURANCE COVERAGE – MED PAYDate of 1st Visit _____

Account # _____

Patient Name _____

Insured Name _____

Insurance Company _____

Adjuster Name _____

Address _____

City, State, Zip _____

Phone # _____

Claim/Policy # _____

Date of Accident _____

What State _____

Med Pay Amount _____

What amount is left _____

Need a copy of the insurance card

HEALTH INSURANCE INFO

Insurance Company _____

Insured Name _____

Need a copy of the insurance card

OTHER PARTIES INSURANCE COVERAGE – AT FAULT

Name of Driver _____

Insured Name _____

Insurance Company _____

Adjuster Name _____

Address _____

City, State, Zip _____

Phone # _____

Claim/Policy # _____

Include a copy of the police report if available

ATTORNEY

Attorney Name _____

Phone # _____

Address _____

City, State, Zip _____

Do you have questions regarding Insurance? Do you need an attorney?

Whether you will need the services of an attorney in dealing with insurance matters will depend on many factors. Your healthcare provider has plenty of experience in treating collision victims, but is not qualified to give out legal advice regarding insurance matters. Should you decide to seek advice from an attorney, it is advisable to find one who specializes in personal injury insurance cases.