AUTOMOBILE INJURY HISTORY

Claim #: _____

Name: _____ Date of accident: _____ Time: _____

Where did accident happen? _____
Describe the accident in your own words: _____
_____
_____

Responsible Party in Accident:
Name of responsible person: _____
Name of responsible person's Insurance Company: _____
Address: _____ Policy Number: _____
Contact Person: _____ Phone #: _____

Name of your Insurance Company: _____
Address: _____ Policy Number: _____
Contact Person: _____ Phone #: _____

Do you have a Medical Payments (Med-Pay) provision in your insurance policy? ☐ Yes ☐ No
If you are not sure, payment is due at time of service until Med-Pay is determined. If you do have Med-Pay we will bill the insurance company and receive payment directly from them. If you don't have Med-Pay payment is expected at time of service.

What was your position in the car?
☐ Driver ☐ Passenger.
If passenger, were you sitting in
☐ Front ☐ Right rear ☐ Left rear
Did your vehicle strike other vehicle?
☐ Yes ☐ No
Was your car struck by other vehicle?
☐ Yes ☐ No
Was the impact from the
☐ Front? ☐ Right side?
☐ Left side? ☐ Rear?
At the time of impact were you looking
☐ Straight ahead? ☐ Right? ☐ Left?
Were both hands on the steering wheel?
☐ Yes ☐ No

Was your foot on the brake? ☐ Yes ☐ No
Were you braced for impact? ☐ Yes ☐ No
Where in the car were you after the accident?
_____
Were you wearing seat belts? ☐ Yes ☐ No
Did you strike anything in vehicle at time of impact? ☐ Yes ☐ No.
If Yes please specify:
☐ Steering Wheel ☐ Side Door
☐ Windshield ☐ Side window
☐ Arm rest ☐ Dashboard
Please state part of body:
☐ Chest ☐ Chin ☐ Knee ☐ Shoulder
☐ Hand ☐ Head

Immediately following the accident, how did you feel? _____
_____
_____

Were you unconscious? ☐ Yes ☐ No
In a daze? ☐ Yes ☐ No
Did you go to the hospital? ☐ Yes ☐ No

If you went to the hospital, when?
☐ At time of accident ☐ Next day
How did you get to hospital?
☐ Ambulance ☐ Private transportation
Did the ambulance attendants place you in a neck collar? ☐ Yes ☐ No
Did they put you in splints? ☐ Yes ☐ No
Did they put you in a brace? ☐ Yes ☐ No
Were you X-rayed at hospital ☐ Yes ☐ No
Were you admitted to the hospital?
☐ Yes ☐ No

If so, what was the diagnosis? _____
Name of hospital: _____
Attended by Dr.:_____ How long did you stay? _____
What treatment was rendered? _____

Describe symptoms from the day following accident to today's date: _____
_____
_____

What recommendations were made?
☐ See own doctor ☐ See orthopedic doctor
☐ Physical Therapy
Before the injury were you capable of working on an equal basis with others your age?
☐ Yes ☐ No

Are your work activities restricted as a result of this accident? ☐ Yes ☐ No
If yes, give percentage of restriction:_____
Are your home activities restricted as a result of this accident? ☐ Yes ☐ No
Do you have a copy of police report?
☐ Yes ☐ No
If Yes, please bring a copy to our office.

_____
Patient Signature

_____
Date