



Motor Vehicle Accident

Name: _____ DOB _____ Date: _____

Address: _____ Phone: _____

Please fill in all of the following to the best of your ability

Date of Accident: _____

At the time of the accident:

Were you the driver or passenger? _____ Sitting in the front or rear? _____

If a traffic violation was issued, to whom was it issued to? _____

Number of people involved in the accident? ___ Did the police come to the accident site? Y N

Was a police report filed? Y N Were you wearing your seatbelt? Y N

Did airbags deploy? Y N Was the headrest: above below the base of your skull?

Did your vehicle impact another vehicle? Y N Make and model of your vehicle _____

Make and model of their vehicle _____ You were going _____ mph.

They were going _____ mph. Were you gripping the steering wheel? Y N

Did the impact to your vehicle come from the: Front Rear Left Right ?

Were you aware that an accident was about to take place? Y N

At impact, your head was turned: Right Left Forward

After the accident:

Please describe how you felt immediately after _____

Did the accident render you unconscious? Y N How long? _____

Did you feel tightness in the: Chest Arms Neck ? Did your neck move: Forward Backward Sideways ?

Did you feel your: Upper or Lower body move Forward Backward Sideways ?

Did any part of your body make contact with the car, where? _____

Were you bruised, where? _____

Were the paramedics called? Y N Were you taken to the Hospital? Y N

Did you go to the doctor at any time after the accident? Y N Name of Hospital? _____

Did you see a Medical Doctor Orthopedist Chiropractor Dentist Other _____

Name of Doctor(s) seen _____

Describe treatment received _____

Were X-rays taken? Y N Was medication prescribed? Y N What? _____

Have you been able to work since your accident? Y N

Are your work activities restricted because of this accident? Y N

Are your symptoms getting worse or better? _____

Are they constant, or do they come and go? _____

When are your symptoms the worst? AM PM Do not change with time of day

When are your symptoms the best? AM PM Do not change with time of day

Name of Insurance Company _____

Claim # _____

Claim Agent's Name _____

Address _____

Phone Number _____

Insured's Name (if different from patient) _____

Date of Birth _____ Insured's Employer _____

Do you have MedPay? _____ What is your maximum limit? _____

Have you retained an attorney? Y N Name _____ Number _____

NOTE: Payment for all services are your responsibility. If you intend on using any form of insurance, assignment of benefits, an attorney, settlement, or other means of payment, we will assist you in filing for services rendered. **But, any outstanding balance for all services rendered, and not paid, will be your responsibility.** If the account is not paid within 90 days of the date of service, and no financial arrangements have been made, you will be responsible for legal fees, collection agent fees, and any other expenses incurred in collecting your account. Signing below acknowledges this responsibility.

I understand the above information and guarantee this form was completed to the best of my knowledge and understanding. It is my responsibility to inform this office of any changes to the information I have provided.

Patient's (Guardian's) signature _____ Date _____