

AUTOMOBILE ACCIDENT REPORT

Today's date: _____

Our policy is to file with your automobile insurance company under their medical payments or "med-pay" plan. They will pay claims as they receive them no matter who was at fault. If you were not at fault and the other driver's insurance is liable, that insurance will not pay any medical claims until you are done treating and have "settled" with them. We can simultaneously file with the other person's insurance company, eventually they will subrogate with your insurance company and reimburse them for any payment that was made. Answer all questions completely. Thank you.

Name: _____ Accident date: _____ Time: _____ am – pm

THIRD-PARTY INFORMATION

Your Auto Insurance Company: _____

Address: _____

Policy# _____ Claim# _____

Contact Person: _____ Phone: _____

Other Driver's Auto Insurance Company: _____

Address: _____

Policy# _____ Claim# _____

Contact Person: _____ Phone: _____

Other Driver's Name: _____

Your Attorney: _____ Date Retained: ____ - ____ - ____

Address: _____ Phone _____

ACCIDENT DETAILS

Description of the accident: _____

Your speed at impact: _____ mph Site of impact on your car: front back side R - L corner R – L

Seat belts: Yes No Brakes applied: Yes No Air Bag: Yes No Did Seat Break: Yes No

Where were you sitting in the car: driver front seat [middle - right] back seat [left – middle – right]

Road conditions: wet dry icy Visibility: night day good foggy rainy poor

Was your car: gaining speed slowing down steady speed stopped _____

Was the *other* car: gaining speed slowing down steady speed stopped _____

Were you aware of the impending impact: Yes No Which way were you looking: right left front

What part(s) of your body were struck: _____

Type of vehicle you were in: _____ Vehicle of *other* driver: _____

Did you lose consciousness: Yes No Paramedics notified: Yes No Police notified: Yes No

Citations issued: Yes No To whom: _____ For what: _____

AFTER THE ACCIDENT

After the accident, did you go: home ER via ambulance ER via own car ER via another person

to work to family doctor to chiropractor to school _____

Doctor's name: _____ Type of Doctor: _____ Date: _____

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Diagnostics: X-rays of _____ MRI CAT Scan EMG _____

Treatment: hospitalized for ___ days surgery bed rest for ___ days brace physical therapy

medication(s) _____ adjustments ice/heat _____

What symptoms did you immediately feel: _____

What are your present complaints: _____ improving same worse

Severity of pain: mild moderate severe Describe pain: _____

Have you noticed *any* activity restrictions as a result of this injury: Yes No What: _____

Did you have *any* physical complaints before the accident: Yes No What: _____

Were these complaints the result of a previous accident: Yes No Date: _____

Describe details of previous accident: _____