Personal Injury / Motor Vehicle Accident Information

Date: _____

Legal First Name: _____ MI: _____ Last Name: _____

Date and time of accident/incident:_____

Location: _____

Description of accident/incident:_____

_____

_____

If a motor vehicle accident, were you wearing a seatbelt with harness? Y N Not applicable

Were you hospitalized? _____ If so, where? _____

Were x-rays taken? Y N Have you missed work since the accident? Y N If so, how many days? _____

Was a police report made? Y N If so, were you determined to be at fault? Y N

Name(s) of other physician(s) consulted? _____

Attorney: _____ Phone number: _____

Address: _____

PATIENT'S AUTOMOBILE insurance company information (if motor vehicle accident):

Name: _____ Do you have "medical payments" coverage? _____

Address: _____ Phone number: _____

Name of insured (if other than patient): _____

Name of claims manager/adjuster: _____

Claim/case number: _____