ACCIDENT REPORT

Name: ______________________________ **Date:** ________
Last First Middle

Insurance Information			
	My (auto/workman comp.) insurance is:	Claim #	
	My personal insurance is:		
	Driver's name of other vehicle, if applicable:		
	Name of their insurance company?		

Do you have an attorney that has advised you in this claim?	❑ **Yes** ❑ **No**	
Attorney's Name:	Address:	Phone:

ACCIDENT INFORMATION

Date of Accident:	**Hour:**	❑ **AM** ❑ **PM**
Accident Location:		
How did the accident happen?		

If Auto Accident			
	How many people were in the auto?		
	Were you the:	❑ **Driver** ❑ **Passenger (Front Seat)**	❑ **Pedestrian** ❑ **Passenger (Back Seat)**
	Was you car struck from:	❑ **Behind** ❑ **Left Side**	❑ **Front** ❑ **Right Side**
	Did your car strike the other(s) involved?	❑ **Yes** ❑ **No**	❑ **Undetermined**
	Or		
	Did the other car strike yours?	❑ **Yes** ❑ **No**	❑ **Undetermined**

INJURY INFORMATION

What happened to you at the time of impact?		
What did you feel immediately after the accident?		
When did you first notice symptoms from the accident?		
Where were you taken after the accident?		
What was done to you there?		
Did you require post-accident hospitalization?	❑ **Yes** ❑ **No**	Where?
List all the doctors and type of treatment since the accident.		
Have you lost any days from work?	❑ **Yes** ❑ **No**	If yes, what kind of work and when?
Did you return to work?	❑ **Yes** ❑ **No**	If yes, on what date?

Patient's signature:	**Date:**
If minor, parent's signature:	**Date:**

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