ACCIDENT FORM PLEASE COMPLETE

NAME:_____ **DATE OF ACCIDENT:**_____HOUR_____AM___ PM__

LOCATION:_____

IS ACCIDENT THE RESULT OF: ___AUTO COLLISION ___WORK INJURY ____OTHER
IF NOT AUTO COLLISION, PLEASE DESCRIBE THE CIRCUMSTANCES:_____
_____
_____
_____

DID YOU REPORT THE INJURY TO YOUR EMPLOYER? ____YES ____NO
DID THEY RECOMMEND CARE AT OUR OFFICE? ____YES ____NO

IF AUTO, WERE YOU THE _____DRIVER _____PASSENGER ____PEDESTRIAN
WAS ANYONE ELSE IN THE VEHICLE? ___YES ___NO
IF YES WHO?_____
IF AUTO COLLISION, WERE YOU STRUCK FROM ____BEHIND ____RIGHT SIDE ____LEFT SIDE
____FRONT ____VEHICLE WAS PARKED

DID YOUR CAR STRIKE THE OTHER VEHICLE? ____YES ____NO
OR DID THE OTHER STRIKE YOURS? ____YES ____NO ____UNDETERMINED
HOW FAST WERE THE VEHICLES MOVING? _____YOURS _____OTHER VEHICLE
DID THE AIRBAG DEPLOY? ___YES ___NO
WERE YOU WEARING YOUR SEATBELT? ___YES ___NO

WAS THERE A CITATION ISSUED TO: ____YOU ____DRIVER OF OTHER CAR ____DRIVER OF YOUR CAR

LIST THE EXTENT OF THE INJURIES AS YOU KNOW THEM_____
_____
_____

DID YOU REQUIRE POST-ACCIDENT HOSPITALIZATION? ____YES ____NO WHERE?_____
HOW WERE YOU TRANSPORTED TO THE HOSPITAL?_____

CHECK SYMPTOMS YOU HAVE NOTICED SINCE ACCIDENT:

___HEADACHE	___DIZZINESS	___LIGHT BOTHER EYES	___DIARRHEA
___NECK PAIN	___HEAD SEEMS TOO HEAVY	___LOSS OF MEMORY	___FEET COLD
___STIFF NECK	___PINS AND NEEDLES IN ARMS	___EARS RING	___HANDS COLD
___SLEEPING PROBLEMS	___PINS AND NEEDLES IN LEGS	___FACE FLUSHED	___STOMACH UPSET
___BACK PAIN	___NUMBNESS IN FINGERS	___BUZZING IN EARS	___CONSTIPATION
___NERVOUSNESS	___NUMBNESS IN TOES	___LOSS OF BALANCE	___COLD SWEATS
___TENSION	___SHORTNESS OF BREATH	___FAINTING	___FEVER
___IRRITABILITY	___FATIGUE	___LOSS OF SMELL	_____
___CHEST PAIN	___DEPRESSION	___LOSS OF TASTE	_____

SYMPTOMS OTHER THAN ABOVE_____

HAVE YOU LOST ANY DAYS OF WORK? _____YES _____NO **DATES:**_____

INSURANCE COMPANIES INVOLVED:

YOUR COMPANY_____

COMPANY OF PERSON RESPONSIBLE FOR INJURIES_____

HAVE YOU BEEN CONTACTED BY AN INSURANCE ADJUSTER REGARDING THIS CLAIM? _____YES _____NO

ADJUSTER'S NAME_____**PHONE#**_____

YOUR CLAIM#_____

IF YOU DON'T HAVE AN ADJUSTER YET, WHAT IS INS. CO'S PHONE#_____

DO YOU HAVE AN ATTORNEY THAT HAS ADVISED YOU IN THIS CARE? _____YES _____NO

ATTORNEY'S NAME_____**PHONE#**_____

ADDRESS_____

SIGNATURE_____

DATE_____