Traffic Accident Form

Name: _____ Date: _____

Date of Accident: _____ Time of Accident: _____ ☐AM ☐ PM

City of Accident: _____ Street of Accident: _____

Road Conditions at time of accident: ☐ wet ☐ dry ☐ icy ☐other _____

Did the police come to the scene? ☐ Yes ☐No

Were you taken to the hospital? ☐ Yes ☐ No Which Hospital? _____

What City? _____ How did you get to the hospital? _____

Were X-Rays taken? ☐Yes ☐ No What Areas? _____

THE FOLLOWING QUESTIONS PERTAIN TO <u>YOU</u>, THE PATIENT, AND THE VEHICLE <u>YOU</u> WERE IN.

1. Where were you sitting in the vehicle? ☐ front seat driver ☐ front seat passenger ☐ rear seat driver side ☐rear seat passenger side ☐rear seat middle
2. Were you ☐aware or ☐surprised by the collision prior to impact?
3. Which direction was your head turned ? ☐Right ☐ Left
4. At the time of impact was the trunk of your body: ☐pointed straight forward, ☐turned ☐Left ☐Right
5. Did you lose consciousness (black out) upon impact? ☐Yes ☐No If yes, estimate how long. _____
6. How far was the top of the headrest or seatback from the top of your head? _____ inches ☐above ☐ below.
7. Were you wearing your seatbelt? ☐Yes ☐No Did it have a ☐lap and ☐shoulder belt?
8. Was your vehicle stopped at the time of impact? ☐Yes ☐ No If Yes, was your foot on the brake? ☐Yes ☐No. - If No estimate the speed of the vehicle you were in. _____m.p.h.
9. If the vehicle was moving, at the time of impact, was it: ☐slowing down ☐gaining speed ☐traveling at a steady rate of speed?
10. Please describe, to the best of your knowledge, what happened during the accident: _____

    _____

    _____
11. What bleeding cuts did you get during this accident? _____
12. What bruises did you get during the accident? _____
13. What part of the automobile did the following body parts hit?

    A. Heat hit?_____ E. Leg hit? ☐right ☐ left _____

    B. Chest hit? _____ F. Knee hit? ☐ Right ☐left _____

    C. Shoulder hit? _____ G. Other _____

14. List the year, make and model of the vehicle you were in:

Year _____ Make _____ Model _____

15. What is the damage cost to the vehicle you were in? $ _____.

16. What parts of the car broke during the accident? ☐Windshield ☐Side window ☐Right ☐Left ☐Steering wheel ☐Front seat back ☐Other _____

THE FOLLOWING QUESTIONS PERTAIN TO THE OTHER VEHICLE INVOLVED IN THE ACCIDENT.

1. What was the year, make and model of the other vehicle?

Year _____ Make _____ Model _____

2. Was the other vehicle moving at the time of the impact? ☐Yes ☐ No If Yes approximate Speed _____mph.

3. If the other vehicle was moving, was it ☐slowing down ☐gaining speed ☐traveling at a steady speed?

PLEASE CIRCLE THE CURRENT SYPMPTOMS THAT YOU HAVE:

- ☐ Headache
- ☐ Head Seems Heavy
- ☐ Head & Shoulders Heavy
- ☐ Mental Dullness
- ☐ Loss of Memory
- ☐ Equilibrium Problems
- ☐ Excess Perspiration
- ☐ Digestive Disorders
- ☐ Nausea, Vomiting
- ☐ Neck Pain
- ☐ Neck Stiffness
- ☐ Neck Motion Restriction
- ☐ Cold (hands/ feet)
- ☐ Irritatibility
- ☐ Upper Back Pain
- ☐ Upper Back Stiffness
- ☐ Mid Back Pain
- ☐ Mid Back Stiffness
- ☐ Lower Back Pain
- ☐ Lower Back Stiffness
- ☐ Pins & Needles(Arms/Legs)
- ☐ Numbness (Arms/ Hands)
- ☐ Numbness (Legs/ Feet)
- ☐ Tingling (Arms/ Hands)
- ☐ Tingling (Legs/ Feet)
- ☐ Weakness (Arms/ Hands)
- ☐ Weakness (Legs/ Feet)
- ☐ Chest Pain
- ☐ Shortness of Breath
- ☐ Eye Strain
- ☐ Pain Behind Eyes
- ☐ Eyes Lose Focus
- ☐ Double Vision
- ☐ Ears (Buzzing/ Ringing)
- ☐ Loss of Taste
- ☐ Loss of Smell
- ☐ Sinus Trouble
- ☐ Extreme Nervousness
- ☐ Anxiety
- ☐ Fatigue
- ☐ Insomnia
- ☐ Neruitis
- ☐ Face Flushed
- ☐ Fainting
- ☐ Tremors
- ☐ Diarrhea
- ☐ Constipation
- ☐ Heart Palpitations

Do you have pain radiating into your ☐Arms ☐Hands ☐Legs ☐Feet?
Do you have difficulty sitting? ☐Yes ☐ No after how long? _____
Do you have difficulty standing? ☐Yes ☐No after how long? _____
Do you have difficulty lying down? ☐Yes ☐No after how long? _____
How far can you comfortably ride in a car? _____
Do you have difficulty bending ☐forward ☐backward ☐left side ☐right side.
Difficulty lifting: ☐light ☐moderate ☐heavy ☐repetitive
Symptoms other than above _____
If you have been in previous accidents, please list the year of each: _____

INSURANCE COMPANIES INVOLVED:

Insurance Company of vehicle you were in:
Owner of the car: _____
Insurance Company _____
Address _____ Telephone _____
Limits _____ Med Pay _____
Claim Number _____ Adjuster _____

Insurance Company of the other vehicle:
Owner of the other vehicle: _____
Insurance Company _____
Address _____ Telephone _____
Limits _____ Med Pay _____
Claim Number _____ Adjuster _____

Attorney Information:
Name of your Attorney: _____
Address: _____ Telephone _____

Please bring us a copy of the police report.

Auto Insurance Policy: We will not be paid any money on your medical bills by your insurance company until you settle the medical portion of your claim. We will allow six (6) weeks after the date you stop treatment in our office for your insurance to pay the claim. If the insurance has not paid within that time you will be responsible for payment in full.

We are required by law to place a medical lien on the settlement check in order to insure that the insurance company pays your medical bills. This is not a lien on any real property, only the settlement check.

Thank you for your concern and cooperation in this matter. We will work diligently to help you recover as fully as possible in a timely manner. If you have any questions please ask.

I have read, understand and agree to the above.

_____ _____
Signature of Responsible Party Date

_____
Name of Patient

Patient's signature: _____ Date: _____