MOTOR VEHICLE COLLISION/PERSONAL INJURY QUESTIONNAIRE

Please answer all questions completely:

1. Your name and address:

_____
_____
_____

2. Phone Number: _____

3. In your own words, please describe the accident:

_____
_____
_____

4. Where did the accident occur? City/Town: _____ State: _____

5. Date of accident: _____ Time: _____ AM PM

6. Were you the: □ driver □ passenger □ pedestrian

7. If you were the passenger, were you in the □ front seat □ right rear seat □ left rear seat

8. What type of vehicle were you in? _____

9. What type was the other vehicle? _____

10. Did your vehicle strike the other vehicle? □ yes □ no

11. Was your car struck by the other vehicle? □ yes □ no

12. What direction was your vehicle going? _____

13. What direction was the other vehicle going? _____

14. Was the impact from: □ the front □ the rear □ the left side □ the right side

15. What was the approximate speed at the time of the impact?

Your vehicle _____ mph Other vehicle _____ mph

16. What was the weather at the time of the accident? □ dry □ wet

17. Was your vehicle in: □ park □ neutral □ in gear □moving □stopped

18. Were your brakes being applied? □ yes □ no

19. Was your vehicle pushed: □ forward □ backward □ sideways

20. Were you pushed: □ forward □ backward

21. Did your seat have a head restraint (headrest)? □ yes □ no
If yes, what was the position of the headrest: □ low □ mid-position □ high

22. Did your head bend over the headrest? □ yes □no

23. Did your hat/glasses end up in the back seat or near the rear window? □ yes □□ no

24. Did any other part of your body hit the interior of the vehicle? □ yes □□ no
If yes, please specify: □ seatbelt restraints □ steering wheel □ dashboard
□ windshield □ side door □ side window □ other _____

25. Which part of your body hit the interior of the vehicle? □ chest □ head □ chin □ face
□ R - L knee □ R - L shoulder □ R - L hand □ other _____

26. Were you holding onto the steering wheel? □ yes □ no

27. Did you brace your arms? □ yes □ no

28. Did you brace your legs against the floorboard? □ yes □ no

29. Was your ankle turned? □ yes □ no

30. Did the vehicle go into a spin or roll as a result of the impact? □ yes □ no
If yes, explain: _____

31. How much damage was there to the outside of the vehicle? □ none □ some □ a lot

32. How much damage was there to the inside of the vehicle? □ none □ some □ a lot

33. At the point of impact, did you experience pain? Be specific:
_____
_____

34. Immediately after the accident were you: □ conscious □ dazed □ unconscious

35. If you lost consciousness, how long? _____

36. Were you wearing a seat belt? □ yes □ no

37. Did the belt have a shoulder harness? □ yes □ no
If yes, did it contribute to the pain you are experiencing? □ yes □ no

38. At the time of impact were you: □ looking straight ahead □ looking to the right
□ looking to the left □ looking down □looking up

39. Did the seat break as a result of the impact? □ yes □ no

40. Were you surprised by the impact? □ yes □ no

41. Did you go to the hospital? □ yes □ no
If yes, when? □ right after the accident □ next day □ other _____
If yes, how did you get there? □ ambulance □ other: _____

42. If transported by ambulance, did the ambulance attendants place you in a: □ neck brace
□ back brace □ other _____

43. Was any medication or medical supplies given? _____

44. Did you have x-rays taken at the hospital? □ yes □ no

If you went to the hospital, please answer the following:
Name of hospital _____
Name of doctor _____
Diagnosis _____
Treatment Received _____
_____

45. Have you had any similar problems before? □ yes □ no
If yes, explain: _____

46. Are you diabetic? □ yes □ no

47. Do you have high blood pressure? □ yes □ no

48. Do you have low blood pressure? □ yes □ no

49. Do you have arthritis or degenerative joint disease? □ yes □ no

50. What type of work do you do? _____

51. What are your job requirements? _____

52. Have you lost any days of work from your injury(ies)? □ yes □ no
If yes, give dates: _____

Patient Signature _____ Date _____

Witness _____ Date _____

Print Name _____

PERSONAL INJURY INSURANCE COVERAGE

Date _____ Spoke With _____ Number _____

Patient Name _____

Insurance Company _____

Address _____

Phone Number _____

Insured Name _____

Date of Accident _____

Claim Number _____

Policy Number _____

Has the accident been reported? □ yes □ no

Name of adjuster handling claim _____

Will insurance company accept assignment of benefits? □ yes □ no
If not, will they make checks payable to patient and our office? □ yes □ no

GROUP HEALTH INSURANCE

Do you have medical benefits under your auto insurance? □ yes □ no

Insurance Company _____

Address _____

Phone Number _____

Insured Name _____

Agent _____ Policy# _____ Phone _____

Name and address of other party or parties involved in accident:
_____
_____
_____
_____

ATTORNEY INFORMATION

Date _____ Spoke With _____ Number _____

Patient Name _____

Attorney Name _____

Address _____

Phone Number _____

Does your attorney need copies of the bills? □ yes □ no

In the event of settlement, will they protect any unpaid balance? □ yes □ no

Do they have PIP? □ yes □ no Do we file? □ yes □ no

Do they have insurance? □ yes □ no Do we file? □ yes □ no

Can we file liability? □ yes □ no