Auto Injury Information

Name: ______________________________ Phone: ____________________ Account # ________________

Address: ______________________________ City ____________________ State ______ Zip ____________

Auto Accident Information:

Accident Date: ________________ Time: ________________ Was police report made? ☐ **Yes** ☐ **No** Date: ____________

Accident Location: ____

Were you struck from: ☐ Behind ☐ Right Side ☐ Left Side ☐ Front **Were you the:** ☐ Driver ☐ Passenger

Describe the Accident: ____

____

Were you injured? ☐ **Yes** ☐ **No** How and where? ____

____

Were you unconscious? ☐ **Yes** ☐ **No** Fractures ____________ Cuts ____________ Abrasions ____________ Bruises ____________

Were you taken to the hospital? ☐ **Yes** ☐ **No** Which one? ______________________________________

Were you hospitalized? ☐ **Yes** ☐ **No** Name of Hospital & Doctor ______________________________

What are your present complaints? ____

____

What treatments have you received to this point? ____

Was there anyone else in the accident with you? ☐ **Yes** ☐ **No** If yes, who? ________________________

Other Doctors Seen for this Condition:

MD / DC / DO / DDS

Doctor's Name: ______________________________ Diagnosis: ______________________________

X-rays: ______________________________ Urinalysis: ______________________________

Blood Tests: ______________________________ Other: ______________________________

Treatment: Medication (s): ______________________________ Shots: ______________________________

Traction: ______________________________ Physiotherapy: ______________________________

Results: ______________________________ Length of time under Dr.'s Care: ________________

Other: ____

Do you have any problems as a result of this injury? ______________________________________

____

Did you miss any time from work? ☐ **Yes** ☐ **No** If yes, how much?: ______________________________

Have you returned to the same job? ☐ **Yes** ☐ **No** If not, why?: ______________________________

Attorney's Name: ______________________________ Phone: ______________________________

Address: ______________________________ Litigation? ☐ **Yes** ☐ **No** ☐ **Maybe**

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Insurance Company: ______________________________ Claim Number: ______________________________

Address: ______________________________ Adjuster: ______________________________

____ Adjuster's Phone: ______________________________

Patient Signature: ______________________________________ Date: ____________________