Phone Number:

Accident Information

Date and time of accident: _____ First Name: _____ Last Name: _____

Name of the location/street on which you were traveling: _____

Where you the: ◯ Driver ◯ Front Passenger ◯ Rear Passenger Make and model of the vehicle you were occupying: _____

Was this vehicle equipped with airbags? ◯ Yes ◯ No Did the airbags inflate? ◯ Yes ◯ No Were you wearing a seat belt? ◯ Yes ◯ No

Did the impact to you vehicle come from the: ◯ Front ◯ Rear ◯ Right side ◯ Left side ◯ Other

In relation to the base of your skull, where was the headset? ◯ Above ◯ Below ◯ At the base

In which direction were you headed? ◯ North ◯ South ◯ East ◯ West

Direction the other vehicle was headed? ◯ North ◯ South ◯ East ◯ West

During impact, were you facing: ◯ Forward ◯ Right ◯ Left

Did any part of your body strike anything in the vehicle? ◯ Yes ◯ No Explain: _____

Did the accident render you unconscious? ◯ Yes ◯ No If yes, for how long? _____

What was the approximate speed of the your vehicle? _____ the OTHER vehicle? _____

Were you ◯ Aware ◯ Suprised by the impact

What did your vehicle impact? ◯ A Vehicle ◯ Other

If other, please explain below:

Number of people in the accident vehicle: _____

Please list the names of the victims in this accident:

If your own words, please describe the accident:

Please describe how you felt immediately after the accident:

Legal Information

Did the police come to the accident scene? ◯ Yes ◯ No Was a police report filed? ◯ Yes ◯ No

Were there any witnesses? ◯ Yes ◯ No Was a traffic violation issued? ◯ Yes ◯ No To whom: _____

Have you retained an attorney? ◯ Yes ◯ No If yes, whom? _____ Phone: _____

Medical Information

Have you gone to a hospital or seen any other doctor? ◯ Yes ◯ No When did you go? ◯ Immediately ◯ Next Day ◯ 2 Days Plus

How did you get there? ◯ Ambulance ◯ Private Transportation Was medication prescribed? ◯ Yes ◯ No

Name of the hospital and/or attending doctor: _____

Was he / she a: ◯ D.D.S ◯ M.D. ◯ D.C. ◯ D.O. Were any X-rays taken? ◯ Yes ◯ No

Have you been able to work since this injury? ◯ Yes ◯ No Are you work activities restricted as a result of this injury? ◯ Yes ◯ No