

Auto Accident Form

Name _____ Sex _____ Date of Birth _____

Address _____ City _____ State _____ Zip _____

Employer _____ Office phone _____

Employer address _____

Date/Time of Accident _____ Your Insurance Company _____

Policy # _____ Claim # _____

Driver of your vehicle _____ Ins. Co. _____ Policy # _____

Driver of other vehicle _____ Ins. Co. _____ Policy # _____

Where you the driver _____ passenger _____ were you parked _____ moving _____ were you a pedestrian

Where you headed north _____ south _____ east _____ west _____ Street/highway _____

Other vehicle headed _____ on street/highway _____

Did your car strike other car involved? _____ Did other car strike your car? _____

Were you struck from behind? _____ front? _____ left side _____ right side _____ other _____

Were you in the front seat? _____ back seat? _____ using seat belt _____ other _____

Were the police notified? _____ Were you issued a traffic citation? _____ To the driver of the car? _____

To the driver of the other car? _____

Where did you feel pain after the accident? _____

Were you unconscious? _____ for how long? _____

Where were you taken after the accident? _____

What treatment were you given? _____

Was any other Doctor consulted? _____ What was the Doctors name? _____

What was the diagnosis? _____ How often did you see the Dr.? _____

Have you ever had any complaints in the involved area before? _____

If so, what were the complaints? _____

Are your work activities restricted as a result of this accident? _____ Have you lost any days of work? _____

Since the injury are your symptoms improving? _____ getting worse? _____ same? _____

Have you been contacted by an insurance adjuster? _____ Name of adjuster? _____

Have you retained an attorney? _____ Name, address and phone _____

Explain in detail how your accident happened? _____
