Accident/Injury Questionnaire

NAME OF INJURED: __________________________ SSN: _________________________ DOB: ____/____/_____

ADDRESS: ___________________________ CITY: ________________________ STATE: _____ ZIP: ____________

PHONE: (______)__________-__________

PERSONAL INJURY:

RESONSIBLE PARTY'S NAME: ____

ADDRESS: ____________________________ CITY: ________________________ STATE: _____ ZIP: ___________

WERE THERE ANY WITNESSES? ☐ YES ☐ NO IF SO, NAME(S) ____

RESONSIBLE PARTY INS CO.: ____________________________ CLAIM ADJUSTER: ____________________________

CLAIMS ADDRESS: ___________________________ CITY/STATE: ________________________ ZIP: ______________

PHONE: (______)__________-__________ CLAIM NO. ____

HAVE YOU BEEN CONTACTED BY THE OTHER PARTY'S INSURANCE? ☐ YES ☐ NO

HAVE YOU OPENED YOUR MED PAY ACCOUNT WITH THE RESPONISBLE PARTY'S INSURANCE? ☐ YES ☐ NO

ATTORNEY:

NAME: _____________________________________ PHONE: (______)__________-__________ EXT. _________

ADDRESS: ____________________________ CITY: ________________________ STATE: ______ ZIP:___________

HAS YOUR ATTORNEY ADVISED YOU ABOUT YOUR TREATMENT OR INSURANCE COVERAGE? ☐ YES ☐ NO

NATURE OF INJURY:

1. DATE OF INJURY: _____/_____/_____ TIME OF DAY: ___________________
2. WERE YOU: ☐ DRIVER ☐ PASSENGER ☐ FRONT SEAT ☐ BACK SEAT
3. HOW MANY PEOPLE WERE IN YOUR CAR? _________ WERE YOU WEARING SEATBELTS? ☐ YES ☐ NO
4. SIZE OF YOUR VEHICLE? ☐ COMPACT ☐ MIDSIZE ☐ FULLSIZE ☐ PICK-UP ☐ SUV ☐ SEMI
5. WERE YOU STRUCK FROM: ☐ BEHIND ☐ FRONT ☐ RIGHT SIDE ☐ LEFT SIDE

6. DID YOUR AIRBAG(S) DEPLOY?: ☐ YES ☐ NO

7. APPROXIMATE SPEED OF YOUR CAR ___________MPH OTHER CAR? _____________ MPH

8. WERE YOU KNOCKED UNCONSCIOUS? ☐ YES ☐ NO IF SO, HOW LONG? _________________________

9. WERE THE POLICE NOTIFIED? ☐ YES ☐ NO WAS A CITATION ISSUED? ☐ YES ☐ NO

10. IN YOUR OWN WORDS, PLEASE DESCRIBE THE ACCIDENT: ____

    ____

    ____

    ____

11. DID EMS ARRIVE ON THE SCENE? ☐ YES ☐ NO IF SO, WERE YOU TREATED THERE? ☐ YES ☐ NO

12. WERE YOU TAKEN TO A HOSPITAL? ☐ YES ☐ NO IF YES, WHICH HOSPITAL? ________________________

13. DID YOU HAVE ANY PHYSICAL COMPLAINTS **BEFORE THE ACCIDENT**? ☐ YES ☐ NO

    a. IF YES, PLEASE EXPLAIN IN DETAIL: ____

       ____

       ____

14. HAVE YOU BEEN TREATED BY A DOCTOR **SINCE THE ACCIDENT**? ☐ YES ☐ NO

    a. IF YES, PLEASE LIST DOCTOR'S NAME AND ADDRESS: ____

       ____

    b. WHAT TYPE OF TREATMENT DID YOU RECEIVE?:____

       ____

15. SINCE THIS INJURY OCCURRED, ARE YOUR SYMPTOMS ☐ BETTER ☐ WORSE ☐ SAME

16. ANY OTHER PERTINENT INFORMATION? ____

    ____

    ____

    ____