

HISTORY CONTINUED

List any surgeries you have had: _____

Have you ever been hospitalized: _____

Have you had any previous injuries/ accidents? Please list dates and treatment if any:

Do you have a family history of chronic illness? _____

Patient Signature

Date

Please do not write below this line. Proceed to the next page.

Insured's Name: _____ Relationship: _____

Insurance Company: _____

Address: _____ City: _____ ST _____ ZIP _____

Phone: _____ Ext _____ Fax: _____

Claim #: _____ Policy #: _____

Adjustor: _____ Date Called: _____

____ Group ____ Cash ____ Private ____ W/C ____ PIP ____ LOP ____ Other

Deductible: _____ Met: _____ Coverage: _____ Medpay: _____

Additional information: _____

Attorney Name: _____ Phone: _____

Address: _____

Additional

Notes: _____

HISTORY OF ACCIDENT

Date of Accident: ___/___/___

Time of Accident: _____ AM/ PM

Where were you seated: Driver/ Passenger/ Front/ Rear _____

Make/ Model of vehicle you were occupying: _____

Location where the accident occurred: _____

Approximately how fast were you traveling when the accident occurred? _____ MPH.

Make/ Model of other vehicle(s) involved: _____

In your own words, briefly describe the accident: _____

At the time of the accident, which way were you facing? Forward? Turned? _____

Were you surprised by the accident? **Y / N** Were you wearing a seatbelt? **Y / N**

Did the airbags deploy? **Y/ N** Were you rendered unconscious? **Y/ N**

Were the police notified? **Y/ N** Was a report filed? **Y / N** With who? _____

How did you feel immediately following the accident? _____

Is the pain: _____ Getting better _____ No Improvement _____ Getting Worse

Did you go to the hospital? **Y / N** Where: _____ How: _____

Were X-rays/ CT / MRI performed? **Y/ N** Which? _____

Were you prescribed medication? **Y / N** Which? _____

Have you seen another doctor for this injury? **Y / N** Who? _____

Have you been able to work since the accident? **Y / N** Why? _____

What could you do before the accident that you are now unable to do? _____

Do you have an attorney? Y/ N Who? _____

Patient Signature

Date