MOTOR VEHICLE ACCIDENT

Patient name:______________________________ Date of Accident:________________

Insurance Company________________________________ Phone: _________________

Policy #_____________________________ Claim# _______________________

- Do you have MED-PAY on your policy? ❑ YES ❑ NO
  - What is your MED-PAY limit? $__________
- Do you have U/M (Uninsured Motorist Protection)? ❑ YES ❑ NO
- Were you cited in the accident? ❑ YES ❑ NO ❑ Don't Know
- Were you struck from: ❑ Behind ❑ Front ❑ R. Side ❑ L. Side
  - If other, please explain:____
- Did you feel pain immediately? ❑ YES ❑ NO
  - Where? ____
  - If No, when did you first start feeling pain? ________________________________
- Since the injury are your symptoms: ❑ Getting worse ❑ Improving ❑ Staying the same ❑ Changing
  - If changing, please explain: ____
- Were you the: ❑ Driver ❑ Passenger ❑ Pedestrian ❑ Other _______________
- Were you wearing a seatbelt? ❑ YES ❑ NO

INFORMATION ON DRIVER OF VEHICLE AT FAULT

Name: ___________________________________ Phone: _______________________

Address: ____

Policy #: __________________________________ Claim # ______________________

Have you obtained an attorney for this case? ❑ YES ❑ NO

Attorney or Law Firm Name: ____

Address: ____

Phone: ___________________________________ Fax: _________________________