MOTOR VEHICLE COLLISION/PERSONAL INJURY QUESTIONNAIRE

Please answer all questions completely:

1. Your name and address:

_____

_____

_____

2. Phone Number: _____

3. Please describe the collision in your own words:

_____

_____

_____

4. Where did the collision occur? City/Town: _____ State: : _____

5. Date of collision: _____ Time: _____ AM / PM

6. Were you the: ☐ driver ☐ passenger ☐ pedestrian

7. If passenger, were you in the ☐ front seat ☐ right rear seat ☐ left rear seat

8. What type of vehicle were you in? _____

9. What type was the other vehicle? _____

10. Did your vehicle strike the other vehicle? ☐ yes ☐ no

11. Was your car struck by the other vehicle? ☐ yes ☐ no

12. What direction was your vehicle going?_____

13. What direction was the other vehicle going?_____

14. Was the impact from: ☐ the front ☐ the rear ☐ the left side ☐ the right side

15. What was the approximate speed at the time of the impact?

Your vehicle_____ mph Other vehicle_____ mph

16. What was the weather at the time of the collision? ☐ dry ☐ wet ☐ lcy

17. Was your vehicle in: ☐ park ☐ neutral ☐ in gear ☐ moving ☐ stopped

18. Were your brakes being applied? ☐ yes ☐ no

19. Was your vehicle shoved: ☐ forward ☐ backward ☐ sideways

20. Were you shoved: ☐ forward ☐ whipped backward

21. Did your seat have a head restraint (headrest?) ☐ yes ☐ no

22. If yes, what was the position ☐ low ☐ midposition ☐ high

23. Did your head ride over the headrest? ☐ yes ☐ no

24. Did your hat/glasses end up in the back seat or rear window? ☐ yes ☐ no

25. Did any other part of your body hit the interior of the vehicle? ☐ yes ☐ no

26. If yes, please specify: ☐ seatbelt restraints ☐ steering wheel ☐ dashboard ☐ windshield ☐ side door ☐ side window ☐ other

27. Which part of your body? ☐ chest ☐ head ☐ chin ☐ face ☐ R L knee ☐ R L shoulder ☐ R L hand ☐ other

28. Were you holding on to the steering wheel? ☐ yes ☐ no

29. Did you brace your arms against the dash? ☐ yes ☐ no

30. Did you brace your legs against the floorboard? ☐ yes ☐ no

31. Was your ankle turned? ☐ yes ☐ no

32. Did the vehicle go into a spin or roll as a result of the impact? ☐ yes ☐ no

33. If yes, explain:_____

34. How much damage was there to the outside of the vehicle? ☐ none ☐ some ☐ a lot

35. How much damage was there to the inside of the vehicle? ☐ none ☐ some ☐ a lot

36. At the point of impact, where did you experience pain? Be specific:

_____

_____

37. Immediately after the accident were you: ☐ conscious ☐ dazed ☐ unconscious

38. If you lost consciousness, how long?_____

39. Were you wearing a seat belt? ☐ yes ☐ no

40. Did the belt have a shoulder harness? ☐ yes ☐ no

41. If yes, did it contribute to the pain you are experiencing? ☐ yes ☐ no

42. At the time of impact were you: ☐ looking straight ahead ☐ looking to the right ☐ looking to the left looking down ☐ looking up

43. Did the seat break as a result of the impact? ☐ yes ☐ no

44. Were you braced for the impact? ☐ yes ☐ no

45. Were you surprised by the impact? ☐ yes ☐ no

46. Did you go to the hospital? ☐ yes ☐ no

47. If yes, when? ☐ right after the accident ☐ next day ☐ other:_____

48. If yes, how did you get there? ☐ ambulance ☐ other:_____

49. If by ambulance, did the ambulance attendants place you in a: ☐ neck brace ☐ back brace ☐ other:_____

50. Any medication or medical supplies given? _____

51. Did you have x-rays taken at the hospital? ☐ yes ☐ no

If you went to the hospital, please answer the following:

Name of hospital _____

Name of doctor _____

Diagnosis _____

Treatment Received _____

_____

52. Have you had any similar problems before? ☐ yes ☐ no

53. If yes, explain: _____

54. Are you diabetic? ☐ yes ☐ no

55. Do you have high blood pressure? ☐ yes ☐ no

56. Do you have low blood pressure? ☐ yes ☐ no

57. Do you have arthritis or degenerative joint disease? ☐ yes ☐ no

58. What type of work do you do? _____

59. What are your job requirements? _____

60. Have you lost any days of work from this injury? ☐ yes ☐ no

61. If yes, give dates: _____

Patient Signature _____ Date _____

Witness Date _____ Date _____

Print Name _____

PERSONAL INJURY INSURANCE COVERAGE

Date _____ Spoke With _____ Number_____

Patient Name _____

Insurance Company _____

Address _____

Phone Number _____

Insured Name _____

Date of Accident _____

Claim Number _____

Policy Number _____

Has the accident been reported? ☐ yes ☐ no

Name of adjuster handling claim _____

Will company accept assignment of benefits? ☐ yes ☐ no

If not, will they make checks payable to patient and our office? ☐ yes ☐ no

Limits: How much? $ _____ What's left? _____

GROUP HEALTH INSURANCE

Medical benefits under auto insurance? ☐ yes ☐ no

Insurance Company _____

Address _____

Phone Number _____

Insured Name _____

Agent _____ Policy# _____ Phone _____

Name and address of other party or parties involved in collision:

_____

_____

_____

_____

ATTORNEY INFORMATION

Date _____ Spoke With _____Number _____

Patient Name _____

Attorney Name _____

Address _____

Phone Number _____

Does attorney need copies of bills? ☐ yes ☐ no

In the event of settlement, will they protect any unpaid balance? ☐ yes ☐ no

Do they have PIP? ☐ yes ☐ no Do we file? ☐ yes ☐ no

Do they have insurance? ☐ yes ☐ no Do we file? ☐ yes ☐ no

Can we file liability? ☐ yes ☐ no