Motor Vehicle Accident Patient Information

Patient name:_____
Today's date: _____

- What date did the accident occur?

_____
- Were you the driver, front passenger or rear passenger?

_____
- If a traffic violation was issued, to whom was it issued?

_____
- How many people were in the accident vehicle including you?

_____

Please circle appropriate answer for questions below.

- Did the police come to the accident site?	YES	NO
- Was a police report filed?	YES	NO
- Were you wearing your seat belt?	YES	NO
- If the vehicle had airbags, did they deploy?	YES	NO
- Did the accident render you unconscious?	YES	NO
- Did any part of your body strike anything in the vehicle?	YES	NO

If yes, please explain:

_____
_____
_____

- Have you gone to a Hospital or seen any other Doctor?	YES	NO
If yes, how did you arrive there?	AMBULANCE	PRIVATE TRANSPORTATION
- Were x-rays taken?	YES	NO
- Was medication prescribed?	YES	NO

If yes, please list them:_____

- In relation to the base of your skull, where was the headrest?
ABOVE BELOW AT BASE OF SKULL

- Did the impact to your vehicle come from the:
FRONT REAR RIGHT SIDE LEFT SIDE

- During impact, were you facing:
RIGHT LEFT FORWARD

If you are using a lawyer or auto insurance, please list information below.

Lawyer and/or auto insurance-

_____
Address:_____
_____
_____
Phone number:_____
Claim number:_____