# *AUTO ACCIDENT INFORMATION*

Name: ________________________________________________ Date: ___/___/___ File #: ____________

**1) Billing information:**

Your position in the car: ❑ Driver ❑ Front passenger ❑ Right rear passenger ❑ Left rear passenger

❑ Other: ________________________________________________________________________

Vehicle you were in – Make: ___________________ Model: ___________________ Year: ________

Name of driver: ________________________________________________________________________

Address: ____________________________ City: ________________ State: ___ Zip: _______

Insurance company: ______________________________________ Phone #: ____________________

Has a PIP claim been filed? ❑ Yes ❑ No If yes, claim #: ___________________________________

Other vehicle – Make: ___________________ Model: ___________________ Year: ________

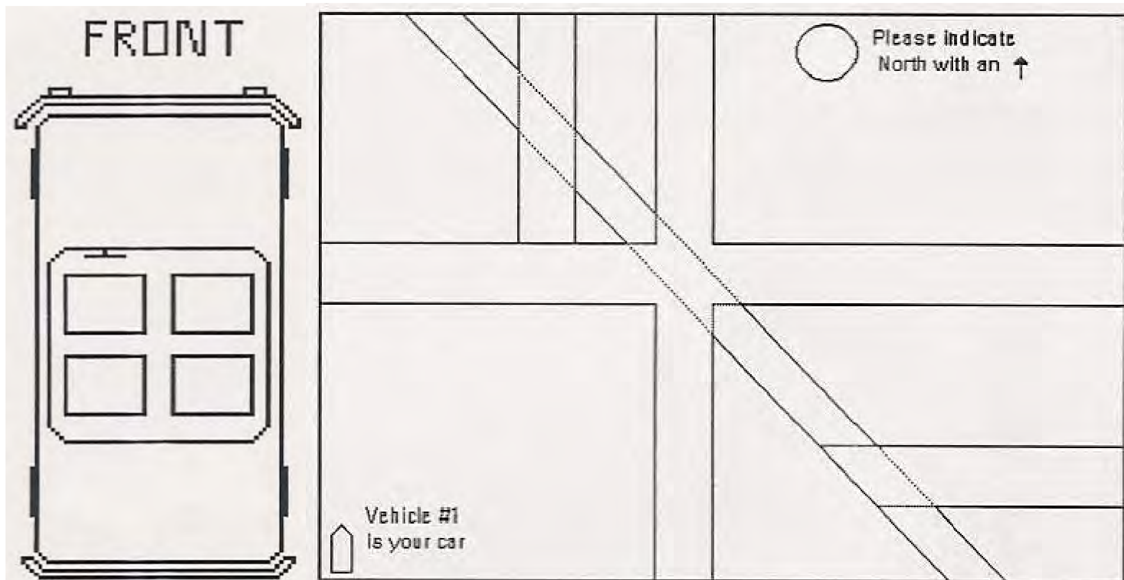
Name of driver: ________________________________________________________________________

Address: ____________________________ City: ________________ State: ___ Zip: _______

Have you consulted with an attorney? ❑ Yes ❑ No
Is an attorney representing you? ❑ Yes ❑ No

If yes, name: ______________________________________ Phone #: ____________________

**2) Mechanics of accident:**




Shade areas of impact & describe how accident occurred: ________________________________

________________________________________________________________________________________

________________________________________________________________________________________

Were you wearing a seatbelt? ❑ Yes ❑ No
Were you wearing a shoulder harness? ❑ Yes ❑ No
Did an airbag deploy at your position? ❑ Yes ❑ No
Was a headrest available at your position? ❑ Yes ❑ No

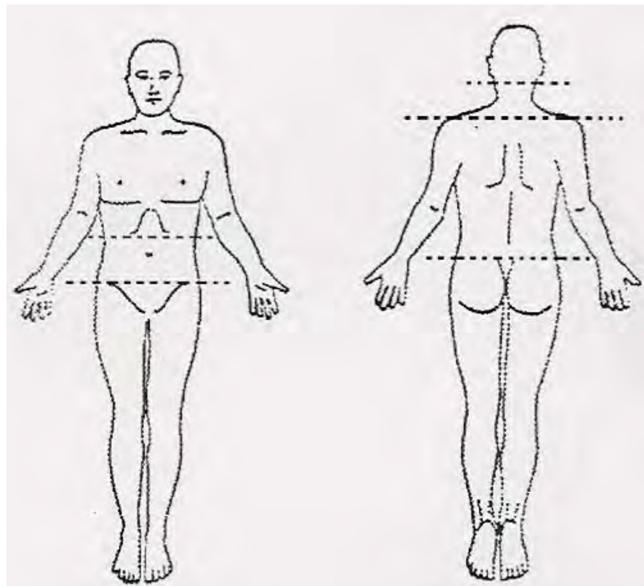
If yes, describe alignment: ______________________________________________________________

At the time of impact, were you aware that an accident was about to occur? ❑ Yes ❑ No
Did you brace for impact? ❑ Yes ❑ No
At the time of the accident, were you: ❑ Looking forward; ❑ Looking to the right;
❑ Looking to the left
At the time of the accident, were you ❑ Stopped; ❑ Moving forward; ❑ Moving backwards;
Approximate speed: _________ mph
Did you have a: ❑ Traffic light (color? ______); ❑ Stop sign; ❑ Yield sign; or ❑ No traffic control
This was a ❑ Head-on collision; ❑ Rear-end collision; ❑ "T-bone" collision; ❑ One care vs. stationary object; ❑ Car-bicycle accident; ❑ Car-pedestrian accident

**4) Environmental conditions:**

Date of accident: ___/___/___; Time of accident: ___:___ ❑ am ❑ pm
The weather was: ❑ Clear; ❑ Cloudy; ❑ Foggy
The road conditions were: ❑ Dry; ❑ Wet; ❑ Icy; ❑ Snow covered
The road surface was: ❑ Concrete; ❑ Asphalt; ❑ Dirt; ❑ Gravel
At the time of the accident, it was: ❑ Raining; ❑ Drizzling; ❑ Snowing; ❑ Hailstorm;
❑ No precipitation

**5) Symptoms and subjective complaints**



Please note on the diagrams above any areas of contusions, bruising, cuts, lacerations, or scrapes.

Did you receive any injuries, bruises, or cuts as a result of the use of seatbelts, shoulder harness, headrest, or airbag deployment? ❑ Yes ❑ No

If yes, please describe: ______________________________________________________________

______________________________________________________________

Did you experience any of the following symptoms after the accident:

| | |
|---|---|
| ❏ Loss of consciousness | ❏ Low back pain |
| ❏ Dizziness | ❏ Low back stiffness |
| ❏ Confusion | ❏ Blurred vision |
| ❏ Tingling in arms or legs | ❏ Disorientation |
| ❏ Numbness in arms or legs | ❏ Warm spots in your body |
| ❏ Neck pain | ❏ Cold spots in your body |
| ❏ Neck stiffness | ❏ Headaches |

Have you had difficulty with any of the following daily activities since the accident?

| | |
|---|---|
| ❏ Sleeping | ❏ Reading |
| ❏ Sitting | ❏ Concentrating |
| ❏ Walking | ❏ Bowel movements |
| ❏ Eating | |

Please list any other daily activities that have been affected as a result of this accident:

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

How did you leave the scene of this accident: ❏ Drove same car; ❏ By ambulance;

❏ By fire department; ❏ By police; ❏ By a friend; ❏ Other: ___________________________

**6) Accident investigation info:**

Location of accident:______________________________________________________________

City: ______________________________ County: _______________________ State: ________

Was this accident investigated by law enforcement? ❏ Yes ❏ No

If yes, which agency: ❏ City police; ❏ County police or sheriff; ❏ State police

Case #:_____________________________________________________

Did you complete a State Accident form? ❏ Yes ❏ No

***It is of the utmost importance that this form be thoroughly completed. Also, please bring in copies of ALL reports that were completed either by you or the police.***