

Phone Number: \_\_\_\_\_

**Accident Information**

Date and time of accident: \_\_\_\_\_ First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Name of the location/street on which you were traveling: \_\_\_\_\_

Where you the:  Driver  Front Passenger  Rear Passenger Make and model of the vehicle you were occupying: \_\_\_\_\_Was this vehicle equipped with airbags?  Yes  No Did the airbags inflate?  Yes  No Were you wearing a seat belt?  Yes  NoDid the impact to you vehicle come from the:  Front  Rear  Right side  Left side  OtherIn relation to the base of your skull, where was the headset?  Above  Below  At the baseIn which direction were you headed?  North  South  East  WestDirection the other vehicle was headed?  North  South  East  WestDuring impact, were you facing:  Forward  Right  LeftDid any part of your body strike anything in the vehicle?  Yes  No Explain: \_\_\_\_\_Did the accident render you unconscious?  Yes  No If yes, for how long? \_\_\_\_\_

What was the approximate speed of the your vehicle? \_\_\_\_\_ the OTHER vehicle? \_\_\_\_\_

Were you  Aware  Suprised by the impactWhat did your vehicle impact?  A Vehicle  Other

If other, please explain below:

Number of people in the accident vehicle: \_\_\_\_\_

Please list the names of the victims in this accident:

If your own words, please describe the accident:

Please describe how you felt immediately after the accident:

**Legal Information**Did the police come to the accident scene?  Yes  No Was a police report filed?  Yes  NoWere there any witnesses?  Yes  No Was a traffic violation issued?  Yes  No To whom: \_\_\_\_\_Have you retained an attorney?  Yes  No If yes, whom? \_\_\_\_\_ Phone: \_\_\_\_\_**Medical Information**Have you gone to a hospital or seen any other doctor?  Yes  No When did you go?  Immediately  Next Day  2 Days PlusHow did you get there?  Ambulance  Private Transportation Was medication prescribed?  Yes  No

Name of the hospital and/or attending doctor: \_\_\_\_\_

Was he / she a:  D.D.S  M.D.  D.C.  D.O. Were any X-rays taken?  Yes  NoHave you been able to work since this injury?  Yes  No Are you work activities restricted as a result of this injury?  Yes  No