## MOTOR VEHICLE INSURANCE INFORMATION

The following information is necessary to bill the insurance. If not complete, claims for your services may be denied because of missing information. This may leave you responsible for the total charges.

**NAME OF POLICYHOLDER**_____

**NAME OF POLICYHOLDER'S LIABILITY INSURANCE** _____

**CLAIM NUMBER**_____

**CLAIMS MAILING ADDRESS**_____

**CLAIMS PHONE NUMBER**_____

**ADJUSTER'S NAME**_____

**DATE OF ACCIDENT**_____

**STATE ACCIDENT OCCURRED IN**_____

**TYPE OF INJURY**_____

## YOUR PERSONAL MEDICAL INSURANCE INFORMATION

In the event that the responsible party's motor vehicle insurance does not pay for your services, we may bill your personal medical insurance. If not complete, claims for your services may be denied because of missing information and may leave you responsible for the total charges.

### MEDICAL POLICY INFORMATION:

Name of Primary Insurance Company:_____

Policy #:_____ Group #:_____

### SUBSCRIBER'S INFORMATION:

Name of Subscriber:_____ Date of Birth:_____

Race: □ Caucasian □ Asian □ African American □ Native American/Alaskan □ Pacific Islander □ Declined

Ethnicity: □ Hispanic □ Non-Hispanic

Address:_____ City:_____ State:____ Zip:_____

Social Security #: _____ Relationship to Patient:_____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

# VEHICLE ACCIDENT INFORMATION

## PATIENT INFORMATION

Name _____ Date _____

Date of accident _____ Time of accident _____ am ____ pm ___

Describe the accident in your words _____

_____

_____

Were you the: ☐ Driver ☐ Front Passenger ☐ Rear Passenger ☐ Pedestrian

How many people were in the accident vehicle? _____

## ACCIDENT SITE

Street/Road Name _____

City/State _____

Nearest intersection with Street _____

Road condition ☐ Dry ☐ Wet ☐ Icy ☐ Other

Which direction were you headed? _____

Speed you were traveling? _____

## VEHICLE

Make and model of vehicle you were in:

_____

Were you wearing a seatbelt? ☐ Yes ☐ No

If yes, what type? ☐ L a p ☐ Shoulder

Was the vehicle equipped with airbags? ☐ Yes ☐ No

If yes, did it/they inflate properly? ☐ Yes ☐ No

Did your seat have a headrest? ☐ Yes ☐ No

If yes, what was the position of the headrest?

☐ Low ☐ Midposition ☐ High

## OTHER VEHICLE

Make and model of other vehicle: _____

Which direction was other vehicle headed? _____

Speed other vehicle was traveling? _____

## IMPACT

Did your car impact another vehicle? ☐ Yes ☐ No

Did your car impact a structure? ☐ Yes ☐ No

If yes, explain _____

_____

Did any part of your body strike anything in the vehicle?

☐ Yes ☐ No If yes, explain _____

Was impact from:

☐ Front ☐ Rear ☐ Left ☐ Right ☐ Other

At time of impact were you:

☐ Looking straight ahead ☐ Looking to the right

☐ Looking to the left ☐ Looking down

☐ Looking up

Were you: ☐ Surprised by impact ☐ Braced for impact

**DRIVER ONLY:**

Were both hands on the steering wheel? ☐ Yes ☐ No

If no, which hand was on the wheel? ☐ Right ☐ Left

Was your foot on the brake? ☐ Yes ☐ No

If yes, which foot was on the brake? ☐ Right ☐ Left

## PATIENT CONDITION

Were you unconscious immediately after the accident?

☐ Yes ☐ No If yes, for how long? _____

Please describe how you felt immediately after the accident? _____

_____

_____

## TREATMENT

Did you go to the hospital? ☐ Yes ☐ No How did you get there? ☐ Ambulance ☐ Private vehicle

When did you go to the hospital? ☐ Immediately after accident ☐ Next day ☐ 2 or more days after

Name of hospital _____ Doctor _____

Diagnosis _____

Treatment received _____

X-rays taken of _____

## SYMPTOMS/INJURIES

Have you been able to work since this injury? ☐ Yes ☐ No How may days have you missed? _____

Prior to the injury were you able to work on an equal basis with others your age? ☐ Yes ☐ No

If you have had any of the following symptoms since your injury, please check:

| | | | |
|---|---|---|---|
| ☐ Arm/shoulder pain | ☐ Feet/toe numbness | ☐ Neck pain | ☐ Fatigue |
| ☐ Back pain | ☐ Hand/finger numbness | ☐ Neck stiffness | ☐ Nausea |
| ☐ Back stiffness | ☐ Headaches | ☐ Shortness of breath | |
| ☐ Chest pain | ☐ Irritability | ☐ Sleep difficulty | |
| ☐ Dizziness | ☐ Jaw problems | ☐ Stomach upset | |
| ☐ Ear buzzing | ☐ Leg pain | ☐ Tension | |
| ☐ Ear ringing | ☐ Memory loss | ☐ Vision blurred | |

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

| | | | | |
|---|---|---|---|---|
| Type of pain: | ☐ Sharp | ☐ Dull | ☐ Throbbing | ☐ Numbness |
| | ☐ Aching | ☐ Shooting | ☐ Burning | ☐ Tingling |
| | ☐ Cramping | ☐ Stiffness | ☐ Swelling | ☐ Other _____ |

How often do you have this pain? _____

Is it constant or does it come and go? _____

Does it interfere with your: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

| | | | |
|---|---|---|---|
| Movements that are painful to perform: | ☐ Sitting | ☐ Standing | ☐ Walking |
| | ☐ Bending | ☐ Lying Down | ☐ Other _____ |

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____

Please Print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient