

AUTO ACCIDENT FORM

Name _____ Today's Date _____

Date of accident _____ Time of accident _____ am pm

Were you the: Driver Passenger in front seat Passenger in back seat

Were you wearing a seat belt? Yes No

Does your vehicle have an airbag? no yes- did it discharge no yes

How many vehicles were involved in the accident? One Two Three Four other _____

How many people were in your vehicle? One Two Three Four other _____

Make and model of your vehicle _____

Make and model of the other vehicle _____

What direction were you headed? North South East West On what street? _____

In what city? _____ In what state? _____

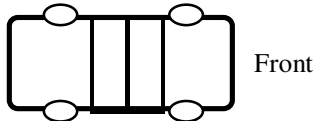
Type of accident: I was hit I hit someone else Rear-ended Broadside Head-on Other _____

Speed of your vehicle: Stopped Braking Moving _____ mph (Approximately) Forward Backward

Speed of the other vehicle: Stopped Braking Moving _____ mph (Approximately) Forward Backward

Visibility at the time of the accident: Good Poor Fair

Draw on the diagram the locations of the impact(s):



Describe the accident in your own words: _____

Were you aware the accident was going to happen before impact? Yes No

Did you brace yourself before impact? Yes No

Head position at the time of impact? Turned Right Left Straight ahead Looking back

Body position at the time of impact? Turned Right Left Straight ahead

Can you recall what parts of your head or body hit what parts of your car during the accident? _____

Could you move all your body parts after the accident? Yes No If no, explain _____

As a result of the accident were you: Shaky / upset Disoriented / confused Rendered unconscious

Have you suffered from memory loss since the accident? Yes No If yes, describe _____

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Did you go to the emergency room? No Yes: Where _____
Were any tests performed? No Yes- X-Rays MRI CAT scan other _____
Were you hospitalized? Yes No If yes, hospital _____

Have you been treated by a physician? Yes No If yes, name: _____

What type of treatment? _____
How often? _____ Results _____
Are you still being treated? Yes No

When did you first notice symptoms immediately within hours that night the next day other _____

Before the accident did you have any of your present complaints in the present or past? Yes No
If yes, describe _____

Have you lost time from work as a result of this accident? Yes No
If yes, list dates lost _____
Type of employment _____

Insurance companies involved:

Insurance company _____
Address _____

Claim # _____ Phone _____
Adjustor's Name _____

Was P.I.P. application filled out? Yes No

Have you retained an attorney? Yes No
If yes, who? _____ Phone _____

Assignment Of Benefits

By signing this form you authorize your insurance company to make payments directly to Rosenthal
Chiropractic, P.A.

Signature of patient or legal guardian

Date