ACCIDENTAL INJURY REPORT

Date of Accident:_____ Time of Injury:_____AM PM

Have you retained an attorney? ☐ Yes ☐ No

Patient's Name_____

Nature of Accident ☐ Auto ☐ Fall ☐ Work Related ☐ Other_____

Have you informed an Insurance Co.? ☐ Yes ☐ No

Name of Ins Co._____

Relationship to Accident_____

Did you go to the Doctor_____ Hospital_____ after the accident?

If yes Name:_____

Type of treatment received:_____

Were you knocked unconscious? ☐ Yes ☐ No If yes, how long? _____

Have you been involved in a similar type of accident before? ☐ Yes ☐ No If yes, please describe (include injuries sustained)._____

Please describe any illnesses, injuries or conditions you had prior to this accident._____

_____

Was anyone else involved in the accident with you? ☐ Yes ☐ No

If yes, who? _____Relationship to you_____

Description of involvement:_____

Have you lost time from work due to this injury? ☐ Yes ☐ No If Yes, please complete the following:

Type of employment_____ Last day worked _____

Are you being compensated for the time lost from work: ☐ Yes ☐ No If Yes, type of compensation? _____

Please describe how you felt:

During the accident:_____

_____

Immediately after the accident:_____

_____

The following day:_____

_____

Check the symptoms you have noticed since the accident:

☐ Headache	☐ Irritability	☐ Short of Breath	☐ Loss of Smell	☐ Cold Sweats
☐ Neck Pain	☐ Chest Pain	☐ Fatigue	☐ Diarrhea	☐ Constipation
☐ Neck Stiff	☐ Dizziness	☐ Depression	☐ Face Flushed	☐ Loss of Ballance
☐ Sleeping Problems	☐ Arms Tingle	☐ Ears Ring	☐ Cold Hands	☐ Pain After Meals
☐ Back Pain	☐ Legs Tingle	☐ Fainting	☐ Cold Feet	☐ Other (Describe):
☐ Nervousness	☐ Hands Numb	☐ Memory Loss	☐ Fever	_____
☐ Tension	☐ Feet Numb	☐ Loss of Taste	☐ Stomach Upset	_____

Please list the extent of injuries as you know them at this time:_____

_____

Since the accident have you symptoms become: ☐ Better ☐ Worse ☐ Remained the same

Do you notice any activity restrictions as a result of this injury? ☐ Yes ☐ No If Yes, please describe:_____

_____

Other pertinent information:_____

_____

Please complete reverse side

☐ Auto

Were you the ☐ Driver ☐ Front Seat Passenger ☐ Back Seat Passenger ☐ Pedestrian?

Number of people in your vehicle:_____ Number of people in the other vehicle?_____

What direction were you headed ☐ North ☐ South ☐ East ☐ West on (Street)_____

Other vehicle was headed: ☐ North ☐ South ☐ East ☐ West on (Street)_____

Were you struck from: ☐ Behind ☐ Front ☐ Left Side ☐ Right Side

or did you strike the other car with your ☐ Front End ☐ Rear End

Were you wearing your seat belt? ☐ Yes ☐ No

Briefly describe the accident including cause(s) and surrounding circumstances:_____

_____

_____

☐ Other

Where were you at the time of the accident?_____

Briefly describe the accident including cause(s) and surrounding circumstances:_____

_____

_____

Name of anyone else involved in or a witness to the accident:_____

Name of responsible party:_____ Phone:_____

Street:_____ City:_____ State:_____ Zip:_____

☐ Fall

Where were you at the time of the accident?_____

Briefly describe the accident including cause(s) and surrounding circumstances:_____

_____

_____

If appropriate, which body part struck the surface, floor, etc.?_____

If in a public place, was property manager notified? ☐ Yes ☐ No

Property Name:_____ Property Manager's Name:_____

Manager's Response:_____

☐ Work Related Accident

Employer:_____ Phone:_____

Street:_____ City:_____ State:_____ Zip:_____

Your job title:_____ Dept:_____

Was any equipment, machinery, and/or object related to the accident? ☐ Yes ☐ No

If yes, what kind?_____

Was the accident reported to the supervisor/employer? ☐ Yes ☐ No

Was a Workers' Compensation claim filed? ☐ Yes ☐ No

Did your supervisor/employer recommend any specific type of care? ☐ Yes ☐ No

If yes, please explain?_____

Patient's Signature:_____ Date:_____

ACCIDENTAL INJURY INSURANCE INFORMATION

Name: _____ Acct # (office use) _____

Date of Accident: _____ Attorney's Name: _____

Firm Name: _____

Date You Verified Ins. Info: _____ Phone #: _____

AUTOMOBILE INSURANCE INFORMATION

It is the policy of this office to file medical claims to the MED PAY portion of your automobile insurance. This part of your insurance policy can be utilized for direct payment while settlement is pending.

PLEASE PROVIDE THIS OFFICE WITH A COPY OF THE POLICE REPORT

Date you reported the accident to your insurance company: _____

Agent's Name: _____ Agency Name: _____

Street: _____ City: _____ State: _____ Zip Code: _____

Phone #: _____ Policy #: _____ Name policy is under: _____

Med Pay Benefit Maximum Amount: _____ Is there a deductible? YES _____ NO _____ If yes, $ _____

Has Med Pay been paid to any other Provider for this claim? YES _____ NO _____ If yes, $ _____

Name of Insurance Company where claims are to be sent: _____

Street: _____ City: _____ State: _____ Zip Code: _____

Adjuster's Name: _____ Phone #: _____

Claim #: _____

AT FAULT INSURANCE COMPANY

__ Same As Above

Name of Person At Fault: _____

Street: _____ City: _____ State: _____ Zip Code: _____

Name of Insurance Company: _____ Phone #: _____

Street: _____ City: _____ State: _____ Zip Code: _____

Agent/Agency Name: _____ Phone #: _____

FALL/OTHER INSURANCE INFORMATION

Type of Policy: ___ Homeowner's ___ Property ___ Liability ___ Other: _____

Name of responsible party: _____ Phone #: _____

Person to whom you spoke: _____

Name of Insurance Company where claims are to be sent: _____

Street: _____ City: _____ State: _____ Zip Code: _____

Adjuster's Name: _____ Phone #: _____

Claim #: _____