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MOTOR VEHICLE ACCIDENT INFORMATION

PATIENT INFORMATION

Today's Date: ____/____/____

Name: _____ SS#: __ __ __ - __ __ - __ __ __ __
First Middle Last

Date of Birth: ____/____/_____ Sex: ☐ Male ☐ Female

(if patient is under 18) Parent/Guardian Name: _____ Parent/Guardian Phone:_____

Address: _____
Street name Apt # City State Zip

Cell Phone: _____ Email: _____@_____.com

Primary Care Physician: _____Physician Phone: _____

Emergency Contact:_____ Contact Phone: _____

ATTORNEY & INSURANCE INFORMATION

Attorney's Name: _____ Attorney's Phone: _____

Attorney's Address: _____

Auto Insurance Name: _____ Insurance Phone: _____

Health Insurance Name: _____ Policy Number:_____

*Please present your insurance card at the front desk

EMPLOYMENT INFORMATION

Are you employed? ☐ Yes ☐ No (If yes) Name of Employer: _____Occupation:_____

Employer Phone: _____ Employer Address: _____

Have you missed time from work because of this accident? ☐ Yes ☐ No Last Date Worked: _____

ACCIDENT INFORMATION

Date of accident ____/____/____ Time: _____ AM PM Make/model of the car you were in: _____

State accident took place in: ☐ RI ☐ MA ☐ Other: _____

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

Were you wearing a seatbelt? ☐ Yes ☐ No If yes, What type: ☐ Lap ☐ Shoulder

Did the airbags deploy? ☐ Yes ☐ No If yes, are there injuries resulting? _____

At the time of impact was your car: ☐ Stopped ☐ Moving If moving, at what speed: _____

Did your car impact another vehicle or structure? ☐ Yes ☐ No

Was the impact from the: ☐ Front ☐ Rear ☐ Left ☐ Right ☐ Other:_____

At the time of impact were you looking: ☐ Straight ahead ☐ To the left ☐ To the right ☐ Looking up ☐ Looking down

Please describe how the accident happened in your own words: _____

_____

_____

Did you go to the hospital or see a doctor? ☐ Yes ☐ No (If yes) Name of hospital or doctor: _____

How did you get to the hospital or doctors? ☐ Ambulance ☐ Private transportation When? _____

Were X-rays taken? ☐ Yes ☐ No Was medication given? ☐ Yes ☐ No

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POLICE INFORMATION

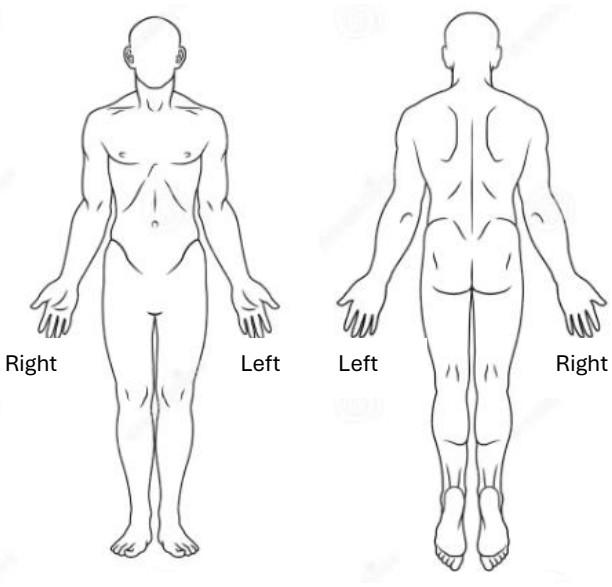
Did the police come to the scene of the accident?: ☐ Yes ☐ No (if yes, please answer questions below)

Was a police report filed? ☐ Yes ☐ No If yes, in what City/State was it filed? _____

If you have a report number, please provide it here: _____

INJURIES/SYMPTOMS

Please mark the area(s) of injury or discomfort on the images below. Indicate the degree of pain on all marked areas using a scale of 1 (least pain) for 10 (severe pain).



Front **Back**

Have you had any of the following symptoms since your injury? Check all that apply

- ☐ Neck Pain
- ☐ Back Pain
- ☐ Arn/Shoulder Pain
- ☐ Knee Pain
- ☐ Leg Pain
- ☐ Feet/Toe Numbness
- ☐ Hand/Finger Numbness
- ☐ Chest Pain
- ☐ Headaches
- ☐ Dizziness
- ☐ Fatigue
- ☐ Memory Loss
- ☐ Nausea
- ☐ Shortness of Breath
- ☐ Sleep Difficulty
- ☐ Upset Stomach
- ☐ Tension
- ☐ Vision Blurred

Type of Pain – Check all that apply:

- ☐ Sharp
- ☐ Aching
- ☐ Cramps
- ☐ Dull
- ☐ Shooting
- ☐ Stiffness
- ☐ Throbbing
- ☐ Burning
- ☐ Swelling
- ☐ Numbness
- ☐ Tingling
- ☐ Other: _____

Is this condition getting progressively worse? ☐ Yes ☐ No Is it constant? ☐ Yes ☐ No

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

Activities or movements that are painful to perform: ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down ☐ Reaching ☐ Lifting ☐ Pushing/Pulling ☐ Prolonged Postures

MEDICAL HISTORY

Have you ever been in an accident before? ☐ Yes ☐ No (if yes, explain)_____

Do you take medication? ☐ Yes ☐ No (if yes, list:) _____

Do you have any health problems? ☐ Yes ☐ No (if yes, explain:) _____

Have you ever had surgery? ☐ Yes ☐ No (if yes, explain:) _____

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 and health.

_____ _____

Signature of Patient, Parent, or Guardian Date

_____ _____

Please print name of Patent, Parent or Guardian Relationship to Patient