AUTO ACCIDENT INFORMATION

Name: _____ Date: ___/___/___ File #: _____

1) Billing information:

Your position in the car: Driver Front passenger Right rear passenger Left rear passenger

Other: _____

Vehicle you were in – Make: _____ Model: _____ Year: _____

Name of driver: _____

Address: _____ City: _____ State: ___ Zip: _____

Insurance company: _____ Ins Phone #: _____

Adjuster Name:_____ Adjuster Phone #:_____

Has a PIP claim been filed? Yes No If yes, claim #: _____

Other vehicle – Make: _____ Model: _____ Year: _____

Name of driver: _____

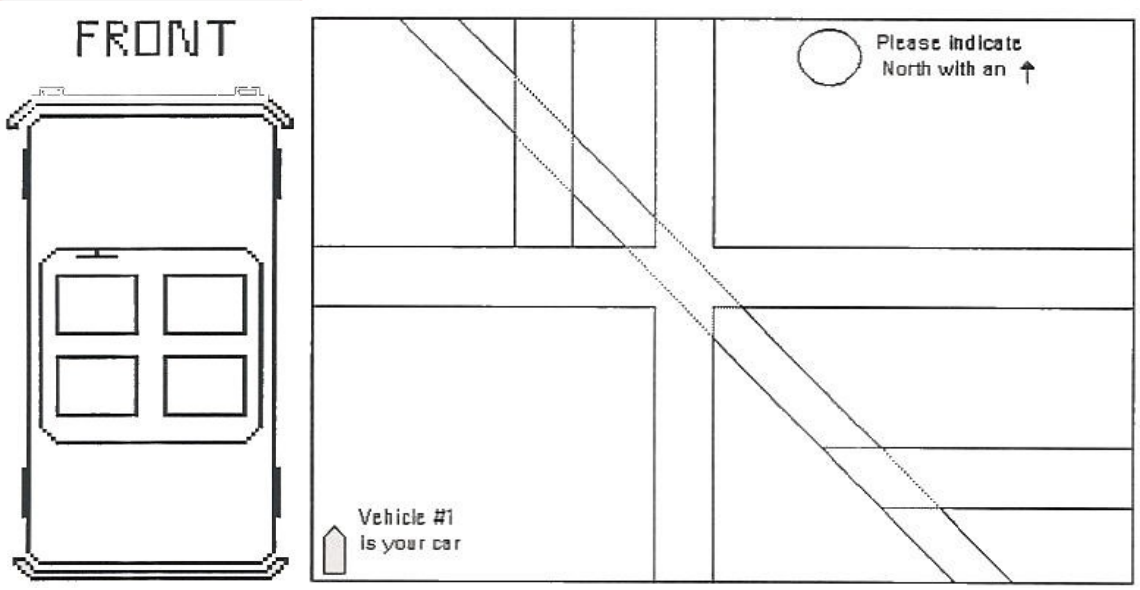
Address: _____ City: _____ State: ___ Zip: _____

Insurance Co: _____ Claim #:_____

Have you consulted with an attorney? Yes No Is an attorney representing you? Yes No

If yes, name: _____ Phone #: _____

2) Mechanics of accident:



Shade areas of impact Describe how accident occurred:_____

_____

_____

Were you wearing a seatbelt? Yes No

Were you wearing a shoulder harness? Yes No Did an airbag deploy at your position? Yes No
Was a headrest available at your position? Yes No

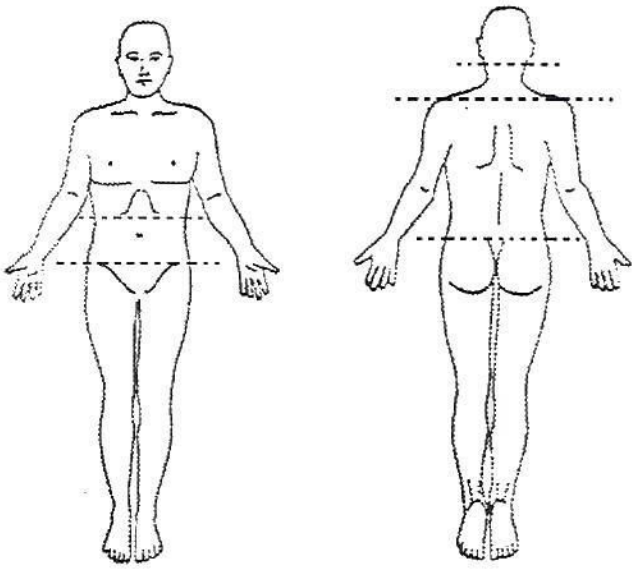
If yes, describe alignment: _____

At the time of impact, were you aware that an accident was about to occur? Yes No
Did you brace for impact? Yes No
At the time of the accident, were you: Looking forward; Looking to the right; Looking to the left
At the time of the accident, were you Stopped; Moving forward; Moving backwards;
Approximate speed: _____ mph
Did you have a: Traffic light (color? _____); Stop sign; Yield sign; or No traffic control
This was a Head-on collision; Rear-end collision; "T-bone" collision; One care vs. stationary object; Car-bicycle accident; Car-pedestrian accident

4) Environmental conditions:

Date of accident: ___/___/___; Time of accident: ___:___ am pm The weather was: Clear; Cloudy; Foggy
The road conditions were: Dry; Wet; Icy; Snow covered The road surface was: Concrete; Asphalt; Dirt; Gravel
At the time of the accident, it was: Raining; Drizzling; Snowing; Hailstorm; No precipitation

5) Symptoms and subjective complaints



Please note on the diagrams above any areas of contusions, bruising, cuts, lacerations, or scrapes.

Did you receive any injuries, bruises, or cuts as a result of the use of seatbelts, shoulder harness, headrest, or airbag deployment? Yes No
If yes, please describe: _____

_____

Did you experience any of the following symptoms after the accident:

Loss of consciousness	Low back pain
Dizziness	Low back stiffness
Confusion	Blurred vision
Tingling in arms or legs	Disorientation
Numbness in arms or legs	Warm spots in your body
Neck pain	Cold spots in your body
Neck stiffness	Headaches

Have you had difficulty with any of the following daily activities since the accident?

Sleeping	Reading
Sitting	Concentrating
Walking	Bowel movements
Eating	

Please list any other daily activities that have been affected as a result of this accident:

_____

_____

_____

How did you leave the scene of this accident: Drove same car; By ambulance;

By fire department; By police; By a friend; Other: _____

6) Accident investigation info:

Location of accident:_____

City: _____ County: _____ State: _____

Was this accident investigated by law enforcement? Yes No

If yes, which agency: City police; County police or sheriff; State police

Case #:_____ Did

you complete a State Accident form? Yes No

It is of the utmost importance that this form be thoroughly completed. Also, please bring in copies of ALL reports that were completed either by you or the police.