AUTOMOBILE ACCIDENT HISTORY

Name: _____ Address: _____

Sex: ____ Age: ____ Driver's License #: _____

General Symptoms:

Did you hit any part of your body during the collision (head or chest on steering wheel or dash board? ____ If Yes, which part and how? _____

_____

Did you become/have: **Confused Disoriented Light-Headed Dizzy Nauseous Blurred Vision Ringing in the ears**

Do you still have any symptoms? ____ Which ones? _____

Are you currently suffering from any of the following?
Restlessness Irritability Poor Concentration Memory Loss Insomnia

Did you go to a hospital? _____ If Yes, which hospital?_____
How did you get to the hospital? _____
What parts of your body were x-rayed at the hospital? _____
What did the hospital do for your injuries? _____
Where you bleeding at the time of the accident? _____
What bruises did you sustain during this accident?_____
Did you receive care from any other medical professional? _____ Name? _____
What type of care were you given and for how long? _____
Where did you feel the pain?_____
What are your current
symptoms?_____
Have you ever been injured in a similar manner?____ If Yes, how and when?_____

_____

Accident History:

Date: _____ Time: _____
State how the accident happened in your own words:_____

_____

_____

Were you Driving? **Yes No** Were you a passenger in the: **Front** or **Back**
Were you on the: **Right Side** or **Left Side**
Were you looking straight ahead? **Yes No** If No, then where were you looking?_____
Was it your car? **Yes No** If Not, Who's?_____

Other People in car: Name and Address:

1) _____ Address _____
2) _____ Address _____
3) _____ Address _____

Was your car stopped at the time of impact? **Yes** **No**

If Yes, was the driver's foot also on the brake? **Yes** **No**

If No, then estimate the speed of the vehicle you were in: _____mph

If your vehicle was moving at the time of impact, was it:

slowing down? **Yes** **No** Accelerating? **Yes** **No**

traveling at a steady rate of speed? **Yes** **No**

Were you wearing a seat belt? **Yes** **No** Was the shoulder harness on? **Yes** **No**

Did you receive any injury or bruise from the seat belt? **Yes** **No**

If yes, then describe the injury:_____

How far is the top of the headrest or seatback from the top of your head: _____inches above or below

Was it: **Daylight** **Night** **Dusk** **Dawn**

Were you tired? **Yes** **No** Were you awake? **Yes** **No**

How long had you been in the car?_____

Where were you prior to the accident?_____

What were the weather conditions?_____

What was the posted speed limit? _____ mph How fast were you going? _____ mph

Type of road? **Two Lane** **Four Lane** **Gravel** **Tar**

Did the collision occur at **a stop sign**?____ **a traffic light**?____ **an intersection**?_____

Which area of your car was damaged? **Front** **Back** **Left Side** **Right Side**

What damage was done to your car?

Inside:_____

Outside:_____

Other:_____

Was the other vehicle moving during the collision?_____ Approximate speed? _____mph

If the other vehicle was moving at the time of the collision, was it:

Slowing Down **Accelerating** **Traveling at a steady speed**

What was the damage to the other car? **Yes** **No**

Inside:_____

Outside:_____

What type of vehicle were you driving? Make:_____ Model:_____Year:_____

What condition was your car in prior to the accident?_____

Do you have pictures of the involved automobile? **Yes** **No**

What is the estimated cost damage to the vehicle you were in? $_____

Which of the following parts of your vehicle were damaged during the accident?
Windshield **Right/Left Side Window** **Steering Wheel**
Other_____

What other type of vehicle was involved in the accident? **Car** **Truck** **Motorcycle**
Size and type:_____

Was a police report filed? **Yes** **No** By Police of: **City** **County** **State**
Who was
ticketed?_____
For what?_____

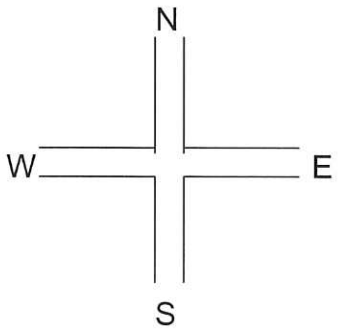
Did your vehicle strike anything else? **Yes** **No**
If Yes, what? **Another Car** **a Sign** **a Tree** **a Bridge** **Other**_____

Did you lose consciousness (black out) on impact? **Yes** **No** How long: _____
Did you experience a flash of light or explosion in your head? **Yes** **No**
Do you remember the impact? **Yes** **No**
Where you aware of the approaching collision prior to impact? **Yes** **No**

Did your vehicle go off the road? **Yes** **No**
If so: **Into an Embankment** **a Ditch** How Deep? _____
Does it bother you to ride in a car now? **Yes** **No** If so, as a: **Driver** **Passenger**

Have you had any time loss from work? **Yes** **No**
Have you had any outside help? **Yes** **No**

Please Draw the Accident:



Have you retained an attorney: ☐ Yes ☐ No
If yes, whom? _____
His/Her phone #:_____

Patient Signature _____ Date _____

PIP Billing

What is PIP?

- Personal Injury Protection is a part of your auto insurance policy. It is designed to take care of you immediately after an accident.

Benefits of PIP..

- PIP is no-fault, so it doesn't matter who caused the accident. You're still covered.
- Most PIP coverage is for one year or $10,000, whichever comes first. Some policies have higher limits.
- PIP covers medical payments, wage loss, and loss of services. There is no deductible.

What is Med Pay?

- Med Pay is a medical-payments-only version of PIP. It does not cover wage loss or loss of services.

A Step-By-Step Guide

1. Call your insurance agent.
2. Ask if you have PIP or Med Pay.
3. If yes, ask about limits on time and dollar amount.
4. Ask your agent to take your report of loss and call it into the claims office.
5. Ask your agent to call back with the claim number, address and the phone number of the claims office.
6. Call the claims office and get the name of the claims adjuster handling your claim.
7. Ask the claims adjuster to mail a PIP Application, Attending Physician's Report and Salary Verification forms.
8. Complete the PIP Application and return it to the claims adjuster.
9. Have your doctor fill out the Attending Physician's report form and return it to you. Mail it to the claims adjuster.
10. Have your employer complete the Salary Verification form and return it to you. Mail it to the claims adjuster.
11. **Provide your claim number and the adjustor's name, office address and phone number in the space provided below.**

Don't Panic! If you have any questions don't hesitate to ask.

Name:_____

Date of Birth:_____

Name of your Insurance Company:_____

Claim Number:_____

Adjuster's Name:_____

Adjuster's Phone Number:_____

Insurance Co. Address:_____

City, State and Zip:_____

Do you have major medical: Yes No

Do you have an attorney: Yes No