Motor Vehicle Accident

Patient Information

Patient Name:____

Address:___________________________ **City:**____________ **Zip:**_______

Home Phone #_________________ **Work Phone #**_____________________

Date of Birth: _________________ **Social Security #**____________________

Date of Injury:_________________ **Time of injury:**______________________

City where crash occurred: ____

Street (location) where crash occurred: ____________________________

What is the estimated damage to your vehicle? $________________________

Name of company / person giving damage estimate:_____________________

Did the police come to the accident scene and make a report? Yes No

Were you cited by the police? Yes No If yes name of officer:______________

Is an attorney currently representing you? Name/Address/Phone

Describe How the Motor Vehicle Crash Happened

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Accident Description (Circle all that apply)

Single-vehicle crash	Two vehicles in crash	Three or more vehicles
Car-to-car crash	Lost control	Rollover
Motorcycle-to-truck crash	Hit guardrail/tree/object	Ran off road

You were the:

Driver	Passenger

Any other people in the vehicle:

Yes	No	If yes name:

Describe the Vehicle You Were In:

Model	Make	Year

Seatbelt Use:

Yes	No	Were you wearing a seatbelt at the time of the accident? Shoulder Harness?
Yes	No	If yes, did the belt cause any injuries?

Describe the Other Vehicle/Object that Your Vehicle Hit: (Circle all that apply)

Small car	Mid-sized car	Full-sized car
Pickup truck/SUV	Large truck	Large bus or Semi-truck
Motorcycle	Pedestrian	Other

Estimated Crash Speeds: (Circle unknown if unable to estimate)

Estimate how fast your vehicle was moving at the time of crash:_____mph	Unknown
Estimate how fast the other vehicle was moving at the time of crash: ___mph	Unknown

At the Time of Impact Your Vehicle Was:

Slowing down	Gaining speed
Stopped	Moving at a steady speed

During and After the Crash, Your Vehicle:

Kept going straight, not hitting anything	Spun around, not hitting anything
Kept going straight, hitting car in front	Spun around, hitting another car
Was hit by a second or third vehicle	Spun around, hitting object other than car
Flipped end-over-end	Other_______________________________

Indicate if Your Body Hit Something or Was Hit by Any of the Following:

Head	Front windshield
Face	Side window
Shoulder	Side door or side of car
Arm/Hand	Steering wheel
Front chest wall	Dashboard
Side chest wall	Pavement/Street surface
Hip/abdomen	Frame of car near windows
Knee	Roof of other vehicle
Leg	Another occupant/animal
Foot	Other___________________

Circle if Any of the Following Parts Broke, Bent, or Were Damaged on Your Vehicle:

Front bumper	Windshields	Trunk
Grill or Hood	Motor	Other___________________
Doors	Rear bumper	Other___________________