

ACCIDENT / INJURY REPORT

Name _____ Date _____ Date of birth _____

Date of accident _____ Time of accident _____ AM / PM

AUTO INJURY

Were you: Driver Passenger Pedestrian

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

Did your car strike the others involved: Yes No Undetermined

Did the other care strike yours: Yes No Undetermined

As a result of the Accident, were traffic citations issued to you? Yes No

ON-THE-JOB INJURY

How did the injury occur? _____

Did you report the injury to your foreman or employer: Yes No

OTHER INJURY

Describe the circumstance of the accident (be specific): _____

CHECK SYMPTOMS YOU HAVE NOTICED SINCE THE ACCIDENT

Headache Ears Ringing Stomach Upset Sleeping Problems

Neck Pain Face Flushed Constipation Depression

Neck Stiff Buzzing in Ears Cold Sweats Lights Bother Eyes

Dizziness Loss of Balance Fatigue Loss of Memory

Back Pain Fever Head Too Heavy Other:

Nervousness Loss of Smell Pins & Needles in Arms

Tension Loss of Taste Pins & Needles in Legs

Irritability Diarrhea Numbness in Fingers

Chest Pain Feet Cold Numbness in Toes

Fainting Hands Cold Shortness of Breath

INSURANCE INFORMATION

Your Insurance Company: _____

Address: _____

Other Party's Name: _____

Address: _____

Other Party's Ins. Co: _____

Address: _____

Have you been contacted by an insurance adjustor regarding this claim? Yes No

If yes, adjustor's name: _____

Address: _____

Phone: _____ Fax: _____

Claim Number: _____

Do you have an attorney that has advised you in this case: Yes No

If yes, attorney's name: _____

Address: _____

RELEASE OF INFORMATION

Our practice is authorized to release information concerning your condition and treatment to your insurance company, attorney, or insurance adjuster for purposes of processing your claim for benefits and payment of services rendered to you.

I attest that all of the above information on this form is correct to the best of my knowledge and I agree to the above statement regarding the release of my medical information.

SIGNATURE

PRINT NAME

DATE