Patient's Accident Account

Date of Accident ____ Time _____________AM / PM

Location of Accident or Injury ____

Type of Accident (Select One) □ Auto Collision □ Work Accident □ Other ______________________

Please Describe the Accident or Injury (in as much detail as possible):

____

____

____

Did you have any bruises? □ Yes □ No Where? ______________________________

Have you been treated before for any of these symptoms? □ Yes □ No

Did you go to the Emergency Room? □ Yes □ No Where? ______________________________

Were you Examined? □ Yes □ No

Were you X-Rayed? □ Yes □ No

Was there treatment given? □ Yes □ No

Medication? □ Yes □ No

Have you seen any other doctors? □ Yes □ No Who? ______________________________________

____

Have you lost any days from work? □ Yes □ No How Many? __________________________

Auto Injury Questions (for Auto Accident Only):

Year/Model of Your Car _______________________ Year/Model of Other Car _______________________

Were you the (Select One): □ Driver □ Passenger □ Pedestrian

Were you struck from (Select One): □ Behind □ Front □ Left Side □ Right Side □ Parked

Did your car strike others involved: □ Yes □ No

Did the other car strike yours: □ Yes □ No

Did you have a seat belt on: □ Yes □ No

Did any part of your body strike the car: □ Yes □ No Which? _______________________

Were traffic citations issued to you: □ Yes □ No

Issued to other drivers: □ Yes □ No

To the driver of the car you were in: □ Yes □ No

Estimated Damage to your vehicle: _____________ Estimated damage to other vehicles: _______________