Southwest Family Physicians

YOUR FAMILY IS OUR FAMILY

Motor Vehicle Accident Injury Data Form

Name: _____

Date of Accident: _____ Time of Accident: _____

Name of Driver: _____ Where were you seated:

_____

Where was the car struck? (Circle) Right Left Rear Front Side Other: _____

Type of Accident: (Circle) Head-on collision Broadside collision Rear-end collision

Front impact, rear-ended car in front Non-collision

Describe in your own words what happened to you upon impact:

_____

_____

_____

Did you see the accident coming? _____ Did you brace for impact? _____

Were seatbelts worn? _____ Were shoulder harnesses worn? _____

Does your car have headrests? _____ Was your car moving at the time of the accident? _____

Head/body position at time of impact? (Circle)

Head turned left/right Head looking back Head looking straight forward

Body straight in Body rotated left/right Other: _____

At the time of the accident, recall what parts of your head or body hit what parts on the inside of the car:

_____

_____

As a result of the accident you were: (Circle)

Rendered unconscious Dazed, circumstance vague Other: _____

Please describe how you felt immediately after the accident: _____

Later that…..Day: _____ Night: _____

The next….Day: _____ Night: _____

Occupation: _____ Employer: _____

Have you missed time from work? Yes No If yes, please explain: _____

Full time off work (dates): _____

Part time off work (dates): _____

I have been unable to work since the accident: Yes No

Did you seek medical help immediately/soon after the accident? Yes No

Doctor/Hospital/Clinic seen: _____

Were you examined? Yes No Were x-rays taken? Yes No

What treatment was given to you? _____

Date of last treatment? _____

Did you have any physical complaints JUST BEFORE THE ACCIDENT? Yes No

If yes, please explain: _____

PRIOR to this accident, have you ever had any symptoms similar to what you are experiencing now? Yes No

If yes, please explain: _____

Did you notice any activities of your home or work routines that are different now than from <u>before</u> the accident?

Yes No

Unable to do: _____

Painful to do: _____

Difficult to do: _____

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Motor Vehicle Accident Insurance Data

Name: _____ Date of Accident: _____

ALL OF THE FOLLOWING INFORMATION IS REQUIRED FOR PERSONAL INJURY PROTECTION INSURANCE PURPOSES

Patient's Private Health Insurance: _____
ID Number: _____ Group Number: _____
Patient's Auto Insurance: _____ Phone: _____
Adjuster's Name: _____ Claim Number: _____
Claim's Address: _____
Phone Number: _____
Policy Holder's Name: _____ Policy Number: _____

Other Driver's Name: _____ Policy Number: _____
Other Driver's Insurance Company: _____ Phone: _____
Do you have an attorney on the case? Yes No
Name: _____ Phone: _____
Address: _____

I HEREBY AUTHORIZE SOUTHWEST FAMILY PHYSICIANS TO DISPENSE TO ANY AND ALL INSURANCE CARRIERS AND ATTORNEYS INVOLVED, ANY AND ALL INFORMATION REQUESTED CONCERNING MY PRESENT INJURIES SUSTAINED IN THE ABOVE-MENTIONED MOTOR VEHICLE ACCIDENT. I HEREBY AUTHORIZE MY INSURANCE COMPANY AND/OR ATTORNEY TO MAKE PAYMENTS, TO THE FULL EXTENT OF MY MEDICAL EXPENSES, DIRECTLY TO SOUTHWEST FAMILY PHYSICIANS.

I UNDERSTAND THAT I AM ULTIMATELY RESPONSIBLE FOR ALL MEDICAL CHARGES INCURRED THROUGH THE OFFICE.

Signature: _____ Date: _____