Auto Accident Questionnaire

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| **General Information** |
| Patient Name: | SS#: | DOB: |
| What part(s) of your body did you injure? |  |
| What **date** did your injury occur? (Be as specific as possible) |  |
| **Where** did your accident/injury occur? (Be as specific as possible) |  |
|  |
| Have you retained an attorney? | [ ]  Yes | [ ]  No |
| If YES, please provide us with your attorney’s information: |
| Attorney’s Name: |  |
| Address: |  |
|  |  |
| Telephone #: |  |
| **Auto Accident** |
| Did your injury arise from an auto accident? | [ ]  Yes | [ ]  No |  |  |  |  |  |
| Does anyone else in your home own a car? | [ ]  Yes | [ ]  No | Do you own any other cars? | [ ]  Yes | [ ] No |
| Did the police come to the accident? | [ ]  Yes | [ ]  No |  |  |  |  |
| Did the police write a report? | [ ]  Yes | [ ]  No |  [ ]   N/A |
| Do you have a copy of the report? | [ ]  Yes | [ ]  No | [ ]  N/A | If yes, please provide us with a copy. |
| Did you receive a ticket for the accident? | [ ]  Yes | [ ]  No | Did the other driver receive a ticket? | [ ]  Yes | [ ]  No |
| Is the other driver going to say this accident was your fault? |  [ ]  Yes |  [ ]  No |
| How much property damage was done to your car? | $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| What was the name of the other driver? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Please provide us with the names, contact information, and claim numbers of all involved insurance companies: |
| **YOUR** Insurance Information | **OTHER PARTY’S** Insurance Information |
| Insurance Co: |  | Insurance Co: |  |
| Address: |  | Address: |  |
|  |  |  |  |
| Telephone #: |  | Telephone #: |  |
| Contact Name: |  | Contact Name: |  |
| Claim #: |  | Claim #: |  |
| Patient Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Date:\_\_\_\_\_\_\_\_\_\_\_\_\_ |