Advantage Physical Therapy
990 Cedar Bridge Ave, Brick, NJ 08723
Ph 732 262-0111 Fax 732 262-0332

Auto Accident Questionnaire

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:_____