AUTO ACCIDENT

Patient Name: **Date:**

Insurance

Primary Name of Auto Policy:	
Policy Number:	
Claim Number:	
Name of Claims Adjuster:	
Auto Carrier Name:	
Auto Carrier Phone Number:	
Attorney:	

Vehicle and Road Description

☐Driver	☐Front Mid Passenger	☐Front Right Passenger	☐Rear Left Passenger
☐Rear Mid Passenger	☐Rear Right Passenger		

Vehicle Make and Model

	Make	Model
Your Vehicle		
Other Vehicle		

Road and Weather Conditions

Road Conditions	☐Dry	☐Damp	☐Wet	☐Ice	☐Snow	
Weather Conditions	☐Clear	☐Sunny	☐Foggy	☐Clouding	☐Raining	☐Snowing

Accident Description

Body Position	☐Leaning Forward	☐Slouched	☐Straight	☐Turned Left	☐Turned Right
Head Position	☐Straight	☐Tilted Forward	☐Turned Left	☐Turned Right	

Accident Description

Headrest Position	☐None	☐Low Position	☐High Position		
Type of Restraint	☐Airbag	☐Lap Belt	☐Shoulder/Lap Belt		
Did Airbags Deploy		☐Yes	☐No		
Direction Body was Thrown	☐Forward then Back	☐Left	☐Right	☐Outside the Vehicle	
Direction Head was Thrown	☐Forward then Back		☐Back then Forward		☐Side to Side
Did you Brace for Impact		☐Yes	☐No		
Did you Hit Anything in the Car		☐Yes	☐No		
Damage to your Vehicle	☐None	☐Minimal	☐Moderate	☐Extensive	☐Complete
Damage to other Vehicle	☐None	☐Minimal	☐Moderate	☐Extensive	☐Complete

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I understand that the information I have provided is current and complete to the best of my knowledge

Signature Date