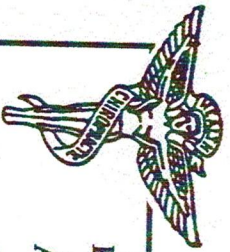


Personal Injury Information



Patient: _____ Today's Date: _____
Address: _____
City: _____ State: _____ Zip: _____

Patient's Auto Insurance Company: _____ Policy: _____
Claims Address: _____
City: _____ State: _____ Zip: _____
Adjuster's Name: _____ Adjuster's Phone: _____
Name of Attorney: _____ Phone: _____
Attorney's Address: _____ City: _____ State: _____ Zip: _____

Driver of Other Vehicle: _____ Address if Known: _____
Insurance Co.: _____ Policy or Claim No.: _____
Claims Address: _____
City: _____ State: _____ Zip: _____
Adjuster's Name: _____ Adjuster's Phone: _____

ACCIDENT DETAILS: Please answer questions on reverse side also.

1. Date of Accident: _____ Time of Day: _____ Road Conditions: _____
2. Were you: () Driver () Passenger () Front Seat () Back Seat () Left Side () Right Side
3. Number of people in your vehicle: _____ Other vehicle: _____
4. City, State & County where accident occurred: _____
5. What direction were you headed? () North () South () East () West
6. What direction was other vehicle headed? () North () South () East () West
7. From what direction were you struck? () Behind () Front () Left Side () Right Side
8. Were you knocked unconscious? () Yes () No If Yes, for how long? _____
9. Were police notified? () Yes () No (Please give receptionist copy of accident report).
10. Describe the accident: _____

Personal Injury Information - Continued

11. Did you have any physical complaints BEFORE the accident? Yes No
Describe: _____

12. What are your present complaints which you attribute to the accident? _____

13. Have you ever been involved in an accident before? Yes No If yes, describe the accident, including date, as well as injuries received: _____

14. Were you taken to a hospital for this present accident? Yes No
Name & address of hospital: _____

15. Have you been treated by another doctor since the accident? Yes No
Name & address of Doctor: _____
What type of treatment did you receive? _____

16. Since this accident, are your symptoms: () Getting worse () Improving () About the same

17. Have you lost time from work as a result of this accident? Yes No
If yes, give last date worked: _____ Type of employment: _____
Present salary: _____ Comments: _____
Are you being compensated for time lost from work? Yes No Type of Compensation: _____

18. What activity restrictions do you notice as a result of this accident? _____

19. Other pertinent information or comments: _____

20. Signature of Patient: _____ Date: _____