


# 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: \_\_\_\_\_  
\_\_\_\_\_