MOTOR VEHICLE COLLISION/PERSONAL INJURY QUESTIONNAIRE

Please fill out form completely. If something does not apply, put N/A.

Patient Name:_______________________________ **Today's Date:**___________________

Date of collision:_____/_____/_____ Time:__________ AM / PM

Where did the collision occur? City/Town:_______________ State:___________

Please describe the collision in your own words:

____

____

____

Part I.

What type of vehicle were you in?____

What type was the other vehicle?____

Were you the: ☐ Driver ☐ Passenger ☐ Pedestrian

If a passenger, were you in the ☐ Front seat ☐ Right rear seat ☐ Left rear seat

Were you wearing a seat belt: ☐ Yes ☐ No Did it have a shoulder harness?: ☐ Yes ☐ No

If yes, did it contribute to the pain you are experiencing?: ☐ Yes ☐ No

Did the seatbelt break as a result of the accident?: ☐ Yes ☐ No

Does your vehicle have an airbag? ☐ Yes ☐ No Did it deploy? ☐ Yes ☐ No

Did you strike your head?: ☐ Yes ☐ No Was there a head restraint (head rest)?: ☐ Yes ☐ No

Part II.

Was your vehicle struck by the other vehicle?: ☐ Yes ☐ No

Did your vehicle strike the other vehicle?: ☐ Yes ☐ No

Did your vehicle go into a spin or roll as a result of the impact?: ☐ Yes ☐ No

Were you surprised by the impact?: ☐ Yes ☐ No

What was the weather like at the time of the accident?: ☐ Wet ☐ Dry ☐ Icy ☐ Snowy

Was there impact from: ☐ Front ☐ Rear ☐ Left Side ☐ Right Side

What was the approximate speed at the time of impact? Your Vehicle:________ Other Vehicle:________

Were you going: ☐ Forward ☐ Backward ☐ Turning Left ☐ Turning Right ☐ Stopped

How much damage was there to the outside of your vehicle?: ☐ None ☐ Some ☐ Major

How much damage was there to the outside of the other vehicle?: ☐ None ☐ Some ☐ Major

PART III.

Immediately after the accident, where did you experience pain? Be specific.

____

____

Immediately after the accident, were you: ☐ Conscious ☐ Dazed ☐ Unconscious, if so, how long?:________

How did you get out of the vehicle?: ☐ On your own ☐ Assisted ☐ Taken out by someone

Did you go to the hospital?: ☐ Yes ☐ No If yes, how did you get there?: ☐ Relative/Friend ☐ Ambulance

If by ambulance, did the ambulance attendants place you in a: ☐ Neck brace ☐ Back brace ☐ Other

If you went to the hospital, did you have x-rays taken?: ☐ Yes ☐ No

If you went to the hospital, or saw another doctor, please answer the following:

Hospital Name:______________________________ Attending Doctor:______________________________

Diagnosis:____

Treatment Received:____

Tests performed:____

Were you admitted to the hospital?: ☐ Yes ☐ No If yes, how long was your stay?:____________________

Were you dismissed from the ER? ☐ Yes ☐ No

Have you missed any work due to this injury?: ☐ Yes ☐ No

What do you do for your job?:____

Patient Signature:____ Date:_______/______/_______

PERSONAL INJURY VERIFICATION FORM

Patient Acct#: **Section 1 - Patient Data** **Date of Injury: / /**

Patient Name:______________________ Primary Policyholder Name:______________________

Relationship to Primary Policyholder: Self - Spouse - Child - Other (Describe______________)

Patient's SS#/ID#:______________________ Patient's DOB:______________

Section 2 - Primary Medical Coverage

Date Called: / /

Total Medical Limit Amount: $______________ Amount Remaining: $______________

Claim #:______________

Has accident been reported? Yes - No - Unsure

Will benefits be paid directly to doctor? Yes - No - Unsure

Has a medical file been opened? Yes - No - Unsure

If No - Will payment be payable to the patient and mailed to Dr.'s office? Yes - No - Unsure

Insured's Policy #:______________ Adjuster's Name:______________

Insurance Co. Name:______________ Insurance Co. Code:______________

Mailing Address:______________________

City, State & Zip:______________________

Phone #:______________ Person Spoke with:______________

Section 3 - Adverse Party Insurance Data

Date Called: / /

Responsible Party Name:______________ Insured's Claim #:______________

Has accident been reported? Yes - No - Unsure

Will benefits be paid directly to doctor? Yes - No - Unsure

Has a medical file been opened? Yes - No - Unsure

If No - Will payment be payable to the patient and mailed to Dr.'s office? Yes - No - Unsure

Insured's Policy #:______________ Adjuster's Name:______________

Insurance Co. Name:______________ Insurance Co. Code:______________

Mailing Address:______________________

City, State & Zip:______________________

Phone #:______________ Person Spoke with:______________

Section 4 - Patient's Attorney Data

Date Called: / /

Attorney's Name:______________ Contact Name:______________

Mailing Address:______________________

City, State & Zip:______________________

Phone #:______________ Fax #:______________

Will Attorney accept or honor a lien for account balance?
Yes - No - Unsure

Does Attorney want copy of the patient's medical bills?
Along the Way - When Patient is Released - Unsure

Date Lien Sent to Atty: ______________ Date Lien Received from Atty: ______________

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