Accident Report

Name: _______________ Last / First / Middle	Date:

Insurance Information:	My auto/workers insurance is:	Claim #
	Insurance Billing Address:	Phone #:

Adjuster Name:		Phone:
Do you have an attorney that has advised you in this claim?	Yes No	Attorney's Name:

Accident Information

We will gladly bill your Personal Auto Insurance, please check with your Insurance and make sure you have PIP coverage.
We **DO NOT** bill any 3rd Party (other parties) Insurance.

Date of Accident:	Hour:	☐ AM ☐ PM

Accident Location:
(Street, City, at work ?)

How did the accident happen?

If Auto Accident:	Driver's name of other vehicle, if applicable:
	Name of their insurance company?
	How many people were in the auto?
	Were you the: ☐ Driver ☐ Passenger (Front Seat) ☐ Pedestrian ☐ Passenger (Backseat)
	Was your car struck from: ☐ Behind ☐ Left Side ☐ Front ☐ Right Side
	Did your car strike the other(s) involved? ☐ Yes ☐ No ☐ Undetermined Or Did the other car strike yours? ☐ Yes ☐ No ☐ Undetermined

Injury Information

Question		
What happened to you at the time of the accident?		
What did you feel immediately after the accident?		
When did you first notice symptoms from the accident? What did you feel?		
Where you taken somewhere after the accident?		
What was done for you there?		
Did you require post-accident hospitalization?	☐ Yes ☐ No	Where?
List all the doctors and type of treatment since the accident.		
Have you lost any days from work?	☐ Yes ☐ No	If yes, what kind of work and when?
Did you return to work?	☐ Yes ☐ No	If yes, on what date?

Patient's signature:	Date:
If minor, parent's signature:	Date: