RANDALL
PAIN MANAGEMENT

Motor Vehicle Accident Information

Name:_______________________________________ Date of Birth:________________

Liability Insurance:_____________________________ Ins. Address:________________________

Adjustor:_________________________ Phone:_________________________Fax:____________

Insured:____________________________ Ins. Policy #:___________________________________

Patient's Auto Ins.:__________________________ Ins. Address:___________________________

Patient's Adjuster:___________________________ Phone:_______________________________

Patient's Policy #:___________________________________ Is Medpay Available? ☐ Yes ☐ No

Date of Accident:_____________ Location of Accident:________________________

Who was at fault?______________________ Describe the Accident in your own words:

1. What was your position in the car?

   Driver: If driver, were your hands on the steering wheel? ☐ Left ☐ Right ☐ Both

   Passenger: If passenger, were you sitting in ☐ Front ☐ Back ☐ Rear

2. Did your vehicle strike another vehicle? ☐ Yes ☐ No

3. Was your vehicle struck by another vehicle? ☐ Yes ☐ No

4. Angles of Impact: ☐ Front ☐ Back ☐ Left ☐ Right

5. Were you wearing a seat belt? ☐Yes ☐ No

6. Did you brace for impact?☐ Yes ☐ No ☐ I braced with my hands ☐ I braced with my feet

7. Which way were you facing at the time of impact? ☐ Straight Ahead ☐ Left ☐ Right

8. Did you strike anything in the vehicle at the time of impact? ☐ Yes ☐ No

If yes, specify what part of your body struck what: ie...head, chest, chin, shoulder, right/left knee

☐ Steering Wheel___________________ ☐ Dashboard_____________________

☐ Windsheild_______________________ ☐ Roof___________________________

☐ Driver Side Door___________________ ☐ Passenger Door_________________

☐ Driver side window_________________ ☐ Passenger Window______________

9. Did the seat back bend/break? ☐ Yes ☐ No

10 Immediately after the accident, how did you feel?☐dizzy/dazed ☐ disoriented ☐ unconscious

☐nervous ☐ nasueous ☐weak ☐ upset ☐ other:______________________________

11. Did you go to the hospital? ☐ Yes ☐ No Were you admitted to the hospital?___________

If so, when did you go? ☐ At the time of accident ☐ Next day ☐ Other______________

How were you transported to the hospital? ☐ Ambulance ☐ Police Car ☐ Private Transportation

Name of Hospital:__________________________________ Location:_____________________________

12. Have you seen any other doctor as a result of the accident? ☐ Yes ☐ No

Doctor's Name:

13. Have you lost any time from work due to your injuries? ☐ Yes ☐ No

If yes, please give dates:____

14. Do you have an attorney for your accident? ☐ Yes ☐ No

Attorney's Name:_______________________________ Law Firm:______________________________

Address:____ Phone:___________________________

______________________________ ____________________

Patient Signature Date