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ACCIDENT INFORMATION

Please take the time to fill out this form completely and accurately. It is important that we have this information for our file. Please use additional sheets if necessary.

PLEASE BRING ANY MEDICAL REPORTS AND X-RAYS TO YOUR APPOINTMENT

Date: ________________

A. PERSONAL INFORMATION

Full Name: ____

Home Address: ____

____

Mailing Address (if different): ____

____

Home Telephone Number: ________________________________

Work Telephone Number: ________________________________

Email: ________________________________

Date of Birth: ________________________________

B. HEALTH INSURANCE INFORMATION

Insurance Company:____

Insurance Company Address:____

Insured:____

Identification No:______________________________

Group No.: ____________________________

C. YOUR VEHICLE

Driver of your vehicle:____

License Number:____

Registration Number:____

Make and Model: ____

D. CAR INSURANCE INFORMATION

Insurance Company:____

Insurance Company Address:____

Insured:____

Policy No:______________________________

E. THE ACCIDENT

Date and time of the accident:____

Place of Accident (streets, intersection and address):____________________________

Weather: ______Clear _____Rain _____Snow _____Fog

Road Surface: _____Asphalt _____Concrete ______Gravel _____Dirt _____Parking Lot

Road Conditions: ______Dry _____Wet _____Icy _____Snow _________Other

Light Conditions: _____Daylight _____Darkness ______Dusk _______Artificial Light

Speed: ______Yours _______Other Vehicle _________Post Limited

Seat Belt: ____________Used ________Not Used

Airbag inflated: _____________Yes ________No

Name of passengers:

Name	Address	Telephone No.
____________________	____________________________	___________________
____________________	____________________________	___________________
____________________	____________________________	___________________
____________________	____________________________	___________________

Describe the damage to your vehicle: ____

____

____

Were you hospitalized as a result of the accident: ________Yes ______No

If Yes: _______By ambulance _______By police _______By private vehicle

If Yes: Name of ambulance, police department or name of person: _______________________

____

____

If Yes: Name of hospital and the names of any medical people that treated you: ___________

____

____

Name(s) and addresses of any treating physicians: ____________________________________

____

____

Describe any injuries in result of the accident:_______________________________________

____

____

Please describe any illnesses or injuries you have had prior to the accident: ____________________

____

____

Were your passengers hospitalized as a result of the accident: ____Yes ______No

If Yes: _______By ambulance _______By police _______By private vehicle

If Yes: Name of ambulance, police department or name of person: ____________________________

____

____

If Yes: Name of hospital and the names of any medical people that treated your passengers:

____

____

Name(s) and addresses of any treating physicians: ____

____

____

Describe any injuries to your passengers: ____

____

____

Please describe any illnesses or injuries they had prior to the accident: _________________________

____

____

Describe in your own words how the accident happened: ______________________________________

____

____

____

F. Sketch of the Accident Scene:

G. OTHER DRIVERS INFORMATION

Full Name:____

Home Address:____

Home Telephone Number: ______________________________

License Number:____

Registration Number:____

Make and Model: ____

Seat Belt: __________Used ________Not Used

Airbag inflated: ___________Yes ________No

Insurance Company (if known):____

Insurance Company Address (if known):____________________________________

Name of passengers:

Name	Address	Telephone No.
________________	______________________	_______________
________________	______________________	_______________
________________	______________________	_______________
________________	______________________	_______________

Describe any injuries in result of the accident (if known):___________________________

____

____

Describe the damage to the other vehicle: ____________________________________

____

____