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A T T O R N E Y S A T L A W

W W W . M A S S F I R M . C O M

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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:

<u>Name</u>	<u>Address</u>	<u>Telephone No.</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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:

<u>Name</u>	<u>Address</u>	<u>Telephone No.</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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

Describe the damage to the other vehicle: _____

