Auto Accident Insurance (Billing) Information

Patient Name:____

Insured's name (if other than patient) ______________________________

Policy #: ____

Insurance Company Name: _________________________________

Phone#: ____

Address: ____________________City: __________________State/Zip:______________

Claim #: __________________________Adjuster's name/phone:____________________

____

AUTOMOBILE ACCIDENT QUESTIONNAIRE

Patient's Name:______________________________ Today's Date:__________

Date of Accident:_____________________________

THE FOLLOWING QUESTIONS PERTAIN TO YOU AND THE VEHICLE YOU WERE IN:

Vehicle type:

❑Car ❑Pickup
❑Van ❑Truck
❑Station Wagon ❑Bus
❑Other______________

Vehicle size:

❑Subcompact ❑Full-size
❑Compact ❑Mini
❑Mid-size ❑Light
❑Heavy ❑Other______________

Your position in the vehicle:

❑Driver
❑Passenger -------- Location-------- ❑Left ❑Middle ❑Right
❑Other _______________ ❑Front Passenger ❑Rear Passenger ❑Third Seat (rear)

Speed of your vehicle:

❑Stopped ❑Moving Moderately
❑Parked ❑Moving Fast
❑Slowing ❑Moving at apprx ____MPH
❑Moving Slowly

Why Vehicle was slowed or stopped:

❑Traffic Signal ❑Parking
❑Pedestrian ❑Traffic
❑Stop Sign ❑Busy Intersection

Collision Type:

❑Driver Side Impact ❑Head On Collision
❑Passenger Side Impact ❑Rear Impact
❑Front Impact ❑Pedestrian Incident

THE FOLLOWING QUESTIONS CONCERN THE OTHER VEHICLE INVOLVED IN THE ACCIDENT:

Vehicle type:

❑Car ❑Pickup
❑Van ❑Truck
❑Station Wagon
❑Other______________

Vehicle size:

❑Subcompact ❑Full-size
❑Compact ❑Mini
❑Bus ❑Mid-size ❑Light
❑Heavy ❑Other______________

CONDITIONS AT THE TIME OF THE ACCIDENT:

Time of day:

❑Full daylight
❑Dawn
❑Dusk
❑Night

Road Conditions:

❑Dry
❑Damp
❑Wet
❑Snow covered
❑Ice covered
❑Patchy Ice/Snow

Visibility:

❑Excellent
❑Good
❑Fair
❑Poor

Visibility compromised by:

❑Brightness
❑Darkness
❑Rain
❑Snow
❑Fog
❑Traffic

THE FOLLOWING QUESTIONS CONCERN THE MOMENT OF IMPACT OF THE ACCIDENT:

Were you...

❑Totally unaware that the accident was impending
❑Aware that the accident was impending
❑Aware that the accident was impending and braced for it

Restraints: (check all that apply)

❑Seat belt
❑Shoulder harness
❑No restraints

If you were the driver of the vehicle, was your foot on the brake pedal? ❑Yes ❑No ❑Knocked off by impact

Was the air bag deployed?

❑Car not equipped with air bag
❑Air bag deployed
❑Air bag not deployed

What position was YOUR headrest in?

❑High position
❑Middle position
❑ Low position

Position of YOUR head at time of impact?
- ❑Facing straight ahead
- ❑Tilted forward
- ❑Rotated to the left
- ❑Rotated to the right

Was your head thrown...?
- ❑Backward and then forward
- ❑Forward then backward
- ❑To the left ❑To the left then the right
- ❑To the right ❑To the right, then the left

Position of Your body at time of impact?
- ❑Straight
- ❑Tilted forward
- ❑Rotated to the left
- ❑Rotated to the right

Was your body thrown...?
- ❑Backward and then forward
- ❑Forward then backward
- ❑To the left ❑To the left then the right
- ❑To the right ❑To the right, then the left
- ❑Across the vehicle
- ❑Outside the vehicle ❑Under the vehicle

Damage to vehicle YOU were in:
- ❑Incurred minimal damage
- ❑Incurred moderate damage
- ❑Incurred severe damage
- ❑Was totalled
- ❑Not known

Citations:
- ❑None issued
- ❑Yourself
- ❑Driver of vehicle patient was a passenger of
- ❑Driver of other vehicle
- ❑Not sure

AS A RESULT OF THE FORCE OF THE COLLISION, WHICH OBJECTS IN THE VEHICLE DID YOUR BODY STRIKE?

Head
- ❑Steering wheel ❑Right door
- ❑Dashboard ❑Left window
- ❑Windshield ❑Right window
- ❑Armrest ❑Console
- ❑Headrest ❑Gear shift
- ❑Rear view mirror ❑Front seat
- ❑Left door ❑Backseat

Left Arm
- ❑Steering wheel ❑Right door
- ❑Dashboard ❑Left window
- ❑Windshield ❑Right window
- ❑Armrest ❑Console
- ❑Headrest ❑Gear shift
- ❑Rear view mirror ❑Front seat
- ❑Left door ❑Backseat

Right Arm
- ❑Steering wheel ❑Right door
- ❑Dashboard ❑Left window
- ❑Windshield ❑Right window
- ❑Armrest ❑Console
- ❑Headrest ❑Gear shift
- ❑Rear view mirror ❑Front seat
- ❑Left door ❑Backseat

Torso
- ❑Steering wheel ❑Right door
- ❑Dashboard ❑Left window
- ❑Windshield ❑Right window
- ❑Armrest ❑Console
- ❑Headrest ❑Gear shift
- ❑Rear view mirror ❑Front seat
- ❑Left door ❑Backseat

Left Leg
- ❑Steering wheel ❑Right door
- ❑Dashboard ❑Left window
- ❑Windshield ❑Right window
- ❑Armrest ❑Console
- ❑Headrest ❑Gear shift
- ❑Rear view mirror ❑Front seat
- ❑Left door ❑Backseat

Right Leg
- ❑Steering wheel ❑Right door
- ❑Dashboard ❑Left window
- ❑Windshield ❑Right window
- ❑Armrest ❑Console
- ❑Headrest ❑Gear shift
- ❑Rear view mirror ❑Front seat
- ❑Left door ❑Backseat

THE FOLLOWING QUESTIONS CONCERN THE TIME PERIOD IMMEDIATELY FOLLOWING THE ACCIDENT:

Did you lose consciousness?
- ❑Yes
- ❑No

Immediately following the accident, did you feel...?
- ❑Dizzy ❑Weak
- ❑Dazed ❑Nervous
- ❑Disoriented ❑Nauseated

Were you able to walk unaided?
- ❑Yes
- ❑No

Where did you go...?

❑Drove home	❑Drove to work
❑Was driven home	❑Was driven to work
❑Drove to hospital	❑Drove to school
❑Was driven to hospital	❑Was driven to school
❑Taken to hospital via ambulance	

Next day discomfort...?
❑increased ❑decreased ❑same

Did your major complaints exist before the accident?
❑Yes ❑ No

In what areas did you IMMEDIATELY feel pain?

❑Head	Shoulder	❑Left	❑Right	Hip	❑Left	❑Right
❑Neck	Arm	❑Left	❑Right	Thigh	❑Left	❑Right
❑Upper back	Elbow	❑Left	❑Right	Knee	❑Left	❑Right
❑Mid back	Wrist	❑Left	❑Right	Calf	❑Left	❑Right
❑Ribs	Hand	❑Left	❑Right	Ankle	❑Left	❑Right
❑Chest	Fingers	❑Left	❑Right	Foot	❑Left	❑Right
❑Abdomen	Buttock	❑Left	❑Right	Toes	❑Left	❑Right
❑Low Back ❑Pelvis						

In what areas did you experience lacerations (cuts)?

❑Head	Shoulder	❑Left	❑Right	Hip	❑Left	❑Right
❑Neck	Arm	❑Left	❑Right	Thigh	❑Left	❑Right
❑Upper back	Elbow	❑Left	❑Right	Knee	❑Left	❑Right
❑Mid back	Wrist	❑Left	❑Right	Calf	❑Left	❑Right
❑Ribs	Hand	❑Left	❑Right	Ankle	❑Left	❑Right
❑Chest	Fingers	❑Left	❑Right	Foot	❑Left	❑Right
❑Abdomen	Buttock	❑Left	❑Right	Toes	❑Left	❑Right
❑Low Back ❑Pelvis						

At the hospital, what areas were x-rayed?

❑Head	Shoulder	❑Left	❑Right	Hip	❑Left	❑Right
❑Neck	Arm	❑Left	❑Right	Thigh	❑Left	❑Right
❑Upper back	Elbow	❑Left	❑Right	Knee	❑Left	❑Right
❑Mid back	Wrist	❑Left	❑Right	Calf	❑Left	❑Right
❑Ribs	Hand	❑Left	❑Right	Ankle	❑Left	❑Right
❑Chest	Fingers	❑Left	❑Right	Foot	❑Left	❑Right
❑Abdomen	Buttock	❑Left	❑Right	Toes	❑Left	❑Right
❑Low Back ❑Pelvis						

Where did you experience pain on the day FOLLOWING the accident?

❑Head	Shoulder	❑Left	❑Right	Hip	❑Left	❑Right
❑Neck	Arm	❑Left	❑Right	Thigh	❑Left	❑Right
❑Upper back	Elbow	❑Left	❑Right	Knee	❑Left	❑Right
❑Mid back	Wrist	❑Left	❑Right	Calf	❑Left	❑Right
❑Ribs	Hand	❑Left	❑Right	Ankle	❑Left	❑Right
❑Chest	Fingers	❑Left	❑Right	Foot	❑Left	❑Right
❑Abdomen	Buttock	❑Left	❑Right	Toes	❑Left	❑Right
❑ Low Back ❑Pelvis						

Patient's Signature:______________________________