Accident Report

Did it happen on the job? If yes, ask receptionist for a Labor and Industries form instead.

*Please fill out **completely***

Name: _____ Today's date: _____

Date of Accident: _____ Time: _____AM / PM
City: _____ County: _____State: _____ Location: _____
Describe how accident happened: _____

_____

List specific areas of bodily discomfort resulting from this accident: _____

_____

Have you had same or similar injuries or symptoms prior to accident? Y / N
Were you hospitalized as a result of the accident? Y / N Where? _____
Have you been treated by another doctor for injuries sustained in the accident? Y / N
Other doctor's name(s) and date(s) seen: _____
What treatments or medications have you received for your symptoms or injuries? _____

_____

Have you missed work because of the accident? Y / N Give dates: _____

Auto Accident

Were you ____Driver ____Passenger ____Pedestrian?
Were you struck from ____Behind ____Right side ____Left side ____Front?
Did your car strike other car(s) involved? Y / N or did car(s) strike yours? Y/ N ____Undetermined
Was a traffic citation issued as a result of the accident? Y / N To whom? _____
Who was at fault? ____Driver of your car ____Driver of other car
Name of your auto insurance company: _____
Claims office address: _____
Adjuster's name: _____Adjuster's phone: _____
Policy # _____ Claim # _____

Do you have an attorney? Y / N Name:_____ Phone: _____
Address: _____

Complete this section if other driver was at fault

Name of at fault driver: _____ Phone: _____
Address: _____
Insurance company: _____
Claims office address: _____
Adjuster's name: _____Adjuster's phone: _____
Policy #_____ Claim # _____

I understand that I am financially responsible for all charges and agree to pay for services. I authorize the doctor to release to my insurance company(ies) any and all information necessary to process my claim. I further authorize that payments be made directly to the physician.

Signature _____ Date _____