ACCIDENT REPORT:

Today's Date: _____

Name:_____Age:_____Date of Birth_____ M F
Address:_____
City:_____State:_____Zip:_____
SS#_____Driver's License #:_____
Date of Accident:_____Time of Day_____A.M. Or P.M.
Location of Accident_____
( ) Automobile Accident ( ) Other
Please describe how the accident happened:_____
_____
_____
_____

Were you the ( ) Driver ( ) Passenger ( ) Pedestrian
Were you struck from ( ) Behind ( ) Right Side ( ) Left Side ( ) Front ( )Auto Parked
Did your car strike other(s) car(s) involved? ( ) Yes ( ) No
Did the other car(s) involved strike your car? ( ) Yes ( ) No
As a result of the accident were citations issued? ( ) Yes ( ) No ( ) To you ( ) To the other driver
Did you require post-accident hospitalization? ( ) Yes ( ) No
List the extent of injuries as you know them:_____
_____
_____
Have you lost any days of work?_____
Insurance company and address:_____
_____
_____
Name of Agent:_____
Name of Insured:_____Policy Number_____Claim Number_____
Have you been contacted by an insurance company regarding this claim? ( ) Yes ( ) No
Have you contacted an Attorney? ( ) Yes ( ) No
If yes: Name_____Address:_____Phone_____

SYMPTOMS:

Please check symptoms you have noticed recently:

( ) Headaches	( ) Dizziness	( ) Light bothers eyes	( ) Diarrhea
( ) Back Pain	( ) Head seems heavy	( ) Loss of memory	( ) Cold feet
( ) Neck stiff	( ) Pins and needles in arms	( ) Ringing in ears	( ) Cold hands
( ) Sleeping Problems	( ) Pins and needles in legs	( ) Face flushed	( ) Upset stomach
( ) Neck pain	( ) Numbness in fingers	( ) Buzzing in ears	( ) Constipation
( ) Nervousness	( ) Numbness in toes	( ) Loss of balance	( ) Cold sweats
( ) Tension	( ) Shortness of breath	( ) Fainting	( ) Fever
( ) Irritability	( ) Fatigue	( ) Loss of smell	( ) Loss of taste
( ) Chest pain	( ) Depression	( )_____	( ) _____

List any other symptoms not listed above_____