AUTOMOBILE ACCIDENT QUESTIONNAIRE

Name: ____ Today's Date: ___/___/___

ACCIDENT DETAILS:

Date of Accident: ___/___/___ Time of Day: _____________ AM PM Location of Accident: __________________

City or town in which accident took place: ___________________________ State: _____

Were you a ☐ Driver ☐ Passenger ☐ Pedestrian Name of Driver (if not you): ______________________________

Were you struck from ☐ Behind ☐ Right Side ☐ Left Side ☐ Front

Were you looking straight ahead, to the left, or to the right? ☐ Straight Ahead ☐ To the Left ☐ To the Right

Was your vehicle ☐ stopped to make a turn ☐ stopped for a traffic signal ☐ parked ☐ moving at the time of impact

Other: ____

Did your body strike anything in the car? ☐ YES ☐ NO Describe in detail: ___________________________________

____

If so were you aware of the impact? ☐ YES ☐ NO What part of the body endured the impact? ____________________

Were you wearing a seat belt? ☐ YES ☐ NO Did you have to readjust the seat after the collision? ☐ YES ☐ NO

Did air bag deploy? ☐ YES ☐ NO

Was weather conditions wet or dry? _______________________

Describe in detail how the accident occurred: ____

____

____

What was the height of the headrest? ________ Were you rendered unconscious as a result of the collision? ☐ YES ☐ NO

Were you taken to the hospital after the accident? ☐ YES ☐ NO By ambulance or private car? ____________________

Were you taken to the hospital *immediately* after the accident? ☐ YES ☐ NO

If not, how much time had elapsed before you went to the hospital? _____________________________________

Which hospital were you taken to? ____

Have you been x-rayed since the accident? ☐ YES ☐ NO If so, where? ____________________________________

Have you received an MRI since the accident? ☐ YES ☐ NO If so, where? ____________________________________

Have you lost any days of work as a result of the accident? ☐ YES ☐ NO If yes, how many days have you lost? ______

Have you ever been in a previous auto accident? Describe all instances, giving approximate dates of the accidents, as well as the injuries sustained, and names of attorneys who represented you.

Date of Accident: ____/____/____ Injuries sustained: ____

Name of Attorney in That Case: ______________________________ Were you a Medicare Patient at the Time? ☐ YES ☐ NO

Approximate Year / Date When Case Settled or Was Resolved: ______________

Date of Accident: ____/____/____ Injuries sustained: ____

Name of Attorney in That Case: ______________________________ Were you a Medicare Patient at the Time? ☐ YES ☐ NO

Approximate Year / Date When Case Settled or Was Resolved: ______________

OTHER AUTO INFORMATION:

Did a police officer write up a police report on the accident? ☐ YES ☐ NO

Do you have a copy of the police report? ☐ YES ☐ NO *(if yes, please provide our office with a copy of this report)*

Was a ticket or citation issued by a police officer as a result of the accident? ☐ YES ☐ NO

Who received the ticket or citation? ____

Do you have any information, including insurance information, concerning the other parties involved in the accident? ☐ YES ☐ NO

(If yes, please provide our office with a copy of this information)

Did the accident involve a *hit-and-run* driver? ☐ YES ☐ NO

Are you, yourself, licensed to drive? ☐ YES ☐ NO *(please provide our office with a copy of your license)*

Was the car in which you were at the time of the accident registered? ☐ YES ☐ NO *(please provide a copy of the registration)*

Other: ____

Were you in your own vehicle or someone else's at the time of the accident? Check one.

☐ My own vehicle ☐ my spouse's ☐ my parent's ☐ a friend's ☐ other

If you were in someone else's vehicle, answer the following:

Name of Owner: ____

Address of Owner: ____

Do you reside with a family member who owns their own vehicle or is insured under some other auto policy? – Automobile insurance laws in applicable states require this info (check all that apply)

☐ Spouse ☐ Father ☐ Mother ☐ Guardian / Foster Parent ☐ Grandparent ☐ Sister / Brother ☐ Child ☐ None

Your Auto Insurance Company (at the time of accident): ____________________ Phone or City: ____________

Agent: ______________________________________ Phone or City: ____________

Was there any property damage to either of the vehicles as a result of the accident?

☐ both vehicles ☐ the other person's vehicle ☐ the vehicle I was in ☐ Neither vehicle was damaged

Have you been contacted by an adjuster from the other party's insurance company regarding this claim? ☐ YES ☐ NO

Adjuster: __________________ Company: __________________ Phone: ______________

Check all that apply: ☐ I have settled my personal injury claim with this company ☐ I have settled the property damage claim

☐ I have signed an agreement which will pay my medical expenses for a period of time (explain):

____

☐ I have not signed any agreement, nor settled any portion of my claim.

Are you currently represented by an attorney? ☐ YES ☐ NO If NO, do you wish to retain an attorney ☐ YES ☐ NO

Name of Attorney: ____________________________ Phone or City: ______________________