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AUTO ACCIDENT INFORMATION FORM

Patient Name:______________________________ Date:________________

Date of Accident:________________ Time of Accident:______________am pm

Were you the (circle one): Driver Passenger / Number of Occupants in car:__________

Make/Model/Year of your car:____

Make/Model/Year of other cars involved:________________________________

Location of accident with names of all streets:____________________________

____

Description of accident (include direction you were going and direction the other car(s) was (were) going:____

____

Please use this space to draw a diagram of the accident:

Dollar amount of damage to your car:___________________________________

Was a police report filed? Yes No
Did you lose consciousness? Yes No
Were you seen in the emergency room? Yes No

Describe your injuries in detail:_______________________________________

____

List all prior hospitalizations, operations, allergies, serious diseases and all medications taken frequently:____

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