MOTOR VEHICLE ACCIDENT REPORT

Patient information:

Patient name: ____
Address: ____
Home phone: _______________________________ Work phone: ____________________________
Date of Birth: ______________________________
Date of injury: _______________________________ Approx. time of injury: __________________________
City and State where crash occurred: ____
Street where crash occurred: ____
Estimated damage to your vehicle: $ __________________________________
Did the police come to the accident scene and make a report? Yes No
Were you cited by the police? Yes No
Name/address/phone of Insurance Company handling the accident claim: ______________________________
____Claim number: ______________________
Is there an attorney currently representing you? Yes No
Name, address, Phone: ____

Description of how the accident happened:

____
____
____
____

Accident description: (Circle all that apply)

Single-vehicle crash	Two vehicles in crash	Three or more vehicles
Car-to-car crash	Lost control	Rollover
Motorcycle to car/truck crash	Hit guardrail/tree/object	Ran off road

You were the: Driver Passenger Any other people in the vehicle: Yes No

Describe the vehicle you were in: Make: __________________ Model: ________________ "Year: _____________

Seatbelt Use:

Yes No Were you wearing a seatbelt at the time of the accident? Shoulder harness?
Yes No If so, did the seatbelt cause any injuries?

Describe the other vehicle/object that your vehicle hit: (circle all that apply)

Small car	Midsized car	Full-sized car
Pickup truck/SUV	Large Truck	Large bus or Semi-truck
Motorcycle	Pedestrian	Other ______________

Estimate crash speeds:

Estimate how fast your vehicle was moving at time of crash: ______________ Unknown
Estimate how fast the other vehicle was moving at time of crash: _____________ Unknown

At the time of the impact your vehicle was:

Slowing down
Stopped
Gaining speed
moving at a steady speed

During and after the crash, your vehicle:

Kept going straight, not hitting anything
Kept going straight, hitting car in front
Was hit by a second or third vehicle
Flipped end-over-end/ Rolled
Spun around, not hitting anything
Spun around, hitting another car
Spun around hitting object other than car
Other

Indicate if your body hit something or was hit by any of the following:

Head
Face
Shoulder
Arm/hand
Front chest wall
Side chest wall
Abdomen
Hip R L
Knee R L
Leg R L
Foot R L
Front windshield
Side window
Side door or side of car
steering wheel
Dashboard
Pavement/street surface
frame of car near window
Roof of another vehicle
Another occupant/animal
Other
____

Circle, if any, parts broken, bent or damaged on your vehicle:

Front bumper
Grill or hood
Doors
Windshields
Motor
Rear bumper
Trunk
Other ____________________________
Other ____________________________

After the accident was your vehicle: Towed Drivable

After the accident were You:

Taken to the hospital by ambulance
Driven to the hospital
If so, Which hospital? ____
Able to drive home
Driven home

If you were taken to the hospital, what was done for you there:

Admitted
X-rays
Medications
Restrictions

Please describe: ____
____
____

To my knowledge, all information I have provided is true.

Signature: ____ **Date:** ______________________