Automobile Accident Questionnaire

Accident Information

Name: ______________________________________________ Date: _______________________

Date of accident: _______________________ Time: _______________________ □ AM □ PM

Driver of car: _______________________ Where were you seated? _______________________

Owner of car: _______________________ Year and model of car: _______________________

Visibility at time of accident: □ Poor □ Fair □ Good □ Other: _______________________

Road conditions at time of accident: □ Icy □ Rainy □ Wet □ Clear □ Dark □ Other: _______________________

Where was your car struck? □ Right □ Left □ Rear □ Front □ Side □ Other: _______________________

Type of accident: □ Head-on collision □ Broad-side collision □ Rear-end collision

□ Front impact, rear-ended car in front □ Non-collision: _______________________

What part of the car was damaged? ______________________________________________

Describe what happened to you upon impact? ______________________________________________

Did you see the accident was about to happen? □ Yes □ No

Did you brace for impact? □ Yes □ No

Were you wearing a seatbelt? □ Yes □ No

Were you wearing a shoulder harness? □ Yes □ No

Does the car have headrests? □ Yes □ No

If yes, what was the position of your headrest?

□ Top of headrest even with bottom of head

□ Top of headrest even with top of head

□ Top of headrest even with middle of head

Was your car braking? □ Yes □ No

Was the other car braking? □ Yes □ No

Was your car moving at the time of the accident? □ Yes □ No

If yes, how fast would you estimate you were going? _________________________________

How fast would you estimate the other car was traveling? _________________________________
What was the position of your head and body at the time of impact?

- Head turned left/right
- Head turned right
- Body straight in sitting position
- Body rotated left/right
- Body rotated right
- Head looking back
- Head straight forward
- Other: _______________________

At the time of the accident, recall what parts of your head or body hit what parts of the vehicle:
_________________________________________________________________________________________________
______________________________________________________________________________________________ __

As a result of the accident were you:

- Rendered unconscious
- Dazed
- Other: _______________________

Could you move all parts of your body?  □ Yes  □ No

If no, why not? ________________________________________________________________

Were you able to get out of the car and walk unaided?  □ Yes  □ No

If no, why not? ________________________________________________________________

Did you have any cuts or bruises from this accident?  □ Yes  □ No

If so, where? ________________________________________________________________

Describe how you felt immediately after the accident: ______________________________________________________

How did you feel later that □ day □ night? ______________________________________________________________

How did you feel the next day(s)? ________________________________________________________________

Check symptoms apparent since the accident:

- Headache
- Loss of taste
- Cold feet
- Tension
- Chest pain
- Fainting
- Sleep problems
- Diarrhea
- Loss of smell
- Cold hands
- Low-back pain
- Constipation
- Dizziness
- Depression
- Loss of balance
- Loss of taste
- Headache
- Loss of smell
- Numbness in fingers
- Mid-back pain
- Fatigue
- Pain behind eyes
- Irritability
- Cold sweats
- Numbness in toes
- Loss of memory
- Ringing in ears
- Shortness of breath
- Nervousness
- Eyes sensitive to light

Have you missed time from work? □ Yes  □ No

Work hours are:  □ Full-time  □ Part-time

If you have missed time from work, how much time have you missed? _______________________

Did the accident occur during your work hours?  □ Yes  □ No

Did you seek medical help immediately/soon after the accident? □ Yes  □ No

If yes, how did you get there? ________________________________________________________________

Doctor/hospital/clinic seen: ______________________ Date: ______________________

What was done? ________________________________________________________________

Were x-rays or other imaging taken? □ Yes  □ No

If yes, of what body part? ________________________________________________________________
What treatments/prescriptions were given? ☐ Bed rest ☐ Brace ☐ Medications ☐ Other: _______________________

What benefit(s) did you receive from treatment(s)?
_________________________________________________________________________________________________
_________________________________________________________________________________________________

Date of last treatment: ___________________________________________________________________________

Are any of your activities of daily living any different now compared to before the accident?
List anything you are unable to do: ____________________________________________________________________
List anything that is painful to do: ____________________________________________________________________
List anything that is difficult to do: ___________________________________________________________________

Indicate on the diagram below how the accident happened:

Comments:
_________________________________________________________________________________________________
_________________________________________________________________________________________________
_________________________________________________________________________________________________
_________________________________________________________________________________________________
_________________________________________________________________________________________________
_________________________________________________________________________________________________
Insurance Information

Do you have an attorney handling this case? ☐ Yes ☐ No

Attorney Name: ________________________________________________________________

Attorney Address: ______________________________________________________________

Patient’s personal insurance: _____________________________________________________

Insured’s name (if other than patient) ____________________________________________ Policy # ______________________

Insurance Company Name: ______________________________________________________

Phone # __________________________

Address: __________________________ City: ______________________________

State: __________________________ Zip: ______________________________

Claim # __________________________

Adjuster’s name and phone # _________________________________________________

Other party’s insurance: _______________________________________________________ 

Insured’s name (if other than patient) ____________________________________________ Policy # ______________________

Insurance Company Name: ______________________________________________________

Phone # __________________________

Address: __________________________ City: ______________________________

State: __________________________ Zip: ______________________________

Claim # __________________________

Adjuster’s name and phone # _________________________________________________

Other insurance: ____________________________________________________________

Insured’s name (if other than patient) ____________________________________________ Policy # ______________________

Insurance Company Name: ______________________________________________________

Phone # __________________________

Address: __________________________ City: ______________________________

State: __________________________ Zip: ______________________________

Claim # __________________________

Adjuster’s name and phone # _________________________________________________
Patient’s Demographic Information

Patient’s full name: ________________________________________________________________

Social Security # _______________________

Address: _________________________________ City: ____________________________

State: ___________________ Zip: _______________________

Date of birth: _______________________

Mailing address (if different): ______________________________________________________

Primary phone # _______________________

Employer name: ___________________________________________________________________

Occupation: __________________________________________________________

Employer’s address: _______________________________ City: _______________________

State: ___________________ Zip: _______________________

Work phone # _______________________

Spouse’s name: _____________________________________________________________

Spouse’s Social Security # _______________________

Spouse’s employer: _____________________________________________________________

Occupation: _____________________________________________________________

Assignment of Payment

My attorney and/or insurance carrier are hereby requested and authorized to pay direct to Daviess Community Hospital any monies due on account, the same to be deducted from any settlement made on my behalf. Further, I agree to pay Daviess Community Hospital the difference, if any, between the total amount of charges on my account and the amount paid by the attorney and/or insurance carrier. It is further understood that I, the undersigned, agree to pay Daviess Community Hospital the full amount of charges on my account should my condition be such that it is not covered by my policy or if for any reason the insurance carrier refuses to pay my claim.

Patient’s signature: __________________________________________ Date: _______________________

Printed name: ________________________________________________

Witness signature: ____________________________________________