INFORMATION SHEET FOR PERSONAL INJURY CLAIM

IF THIS INVOLVES AN AUTOMOBILE ACCIDENT, WAS THERE AN INVESTIGATION BY LAW ENFORCEMENT? ___ YES ___ NO

AGENCY: _____ ACCIDENT REPORT#_____

DO YOU HAVE A COPY OF THE REPORT? ___ YES ___NO

WERE YOU A DRIVER OR A PASSENGER? _____

PLEASE LIST ANY ADDITIONAL OCCUPANTS IN YOUR VEHICLE:

NAME: _____ NAME: _____

ADDRESS: _____ ADDRESS: _____

PHONE: _____ PHONE:_____

You may use the back of this form to list additional passengers, if needed.

WAS AN AMBULANCE CALLED TO ASSIST YOU? ___YES ___NO

YOUR AUTOMOBILE INSURANCE COVERAGE:

COMPANY:_____ POLICY#_____

DO YOU HAVE UNDERINSURED/UNINSURED MOTORIST COVERAGES?
___ YES ___ NO ___ UNCERTAIN

DO YOU HAVE MEDICAL PAYMENTS THROUGH YOUR AUTO INSURANCE?
___ YES ___NO ___UNCERTAIN

DO YOU HAVE HEALTH INSURANCE COVERAGE? ___YES ___ NO

NAME OF COMPANY: _____

POLICY #: _____ GROUP ID#: _____

INFORMATION REGARDING THE OTHER PARTY:

NAME: _____

ADDRESS: _____

AUTO INSURANCE: _____

ADJUSTER AND CLAIM#: _____

YOUR VEHICLE:

WAS YOUR VEHICLE TOWED? ___ YES ___ NO

IF "YES", WHERE WAS YOUR VEHICLE TAKEN?: _____

ARE THERE PHOTOGRAPHS OR VIDEO OF YOUR VEHICLE, THE SITE OF THE INCIDENT, OR THE INCIDENT ITSELF? ___ YES ___NO ___ UNCERTAIN

PLEASE DESCRIBE EXACTLY WHAT HAPPENED:_____

_____

_____

_____

_____

_____

_____

_____

DATE: _____ SIGNATURE:_____

PLEASE LIST THE PAIN AND DIFFICULTIES THAT YOU ARE EXPERIENCING AS A RESULT OF THIS INCIDENT: _____

_____

_____

_____

_____

PLEASE LIST ALL PRIOR INJURIES AND/OR ILLNESSES THAT AFFECT THE AREAS OF INJURY SUSTAINED IN THIS INCIDENT: _____

_____

_____

_____

WORKER'S COMPENSATION: HAVE YOU EVER EXPERIENCED A WORK RELATED INJURY OR ILLNESS? ___YES ___ NO

IF "YES", PLEASE EXPLAIN: _____

_____

_____

_____

ADDITIONAL HISTORY AND INFORMATION: _____

_____

_____

_____

_____

PROVIDER LIST

Primary Care Physician:

1. _____

Ambulance(s):

1. _____

2. _____

Hospital(s) and/or Clinic(s):

1. _____

2. _____

3. _____

Physician(s) and/or Chiropractor(s) (M.D., D.O., D.C.):

1. _____

2. _____

3. _____

4. _____

5. _____

Physical Therapist(s) and any other healthcare providers:

1. _____

2. _____

3. _____