AUTOMOBILE ACCIDENT INFORMATION

Date of accident____/____/____ Time of accident_____ ☐a.m. ☐p.m. Were you the ☐driver ☐passenger

Site of accident, nearest intersection, and direction of travel (i.e. southbound on 405 near Harbor Blvd., etc.)_____

Please describe the accident (i.e. rear ended while stopped, etc.)_____

What is the year, make, and model of the vehicle you were in?_____

What type of vehicle were you in? ☐compact car ☐medium car ☐large car ☐SUV / truck ☐motorcycle ☐other_____

Was there another vehicle involved in the accident? ☐no ☐yes. List year, make, and model_____

What type of vehicle was it? ☐compact car ☐medium car ☐large car ☐SUV / truck ☐motorcycle ☐other_____

What is the estimated speed your vehicle at the time of accident?_____ Of the other vehicle?_____

Which part of your vehicle was struck (i.e. rear, driver's side, etc.)_____

Which part of the other vehicle was struck (i.e. rear, driver's side, etc.)_____

What is the estimated damage to your vehicle?_____ To the other vehicle?_____

Were you wearing a seatbelt? ☐no ☐yes Is your vehicle equipped with airbags? ☐no ☐yes. If yes, did they deploy? ☐no ☐yes

Did you know the accident was about to happen? ☐no ☐yes. If yes, were you bracing yourself? ☐no ☐yes

Did any part of your body strike anything inside the vehicle? ☐no ☐yes. If yes, please describe (i.e. chest hit steering wheel, etc.)_____

Did the police come to the accident scene? ☐no ☐yes. If yes, did they file a report? ☐no ☐yes. If yes, what was the name and station of the officer?_____

Were paramedics called to the accident? ☐no ☐yes. If yes, did you receive any treatment from them? ☐no ☐yes. If yes, please describe that treatment (i.e. evaluation only, neck brace, etc.)_____

Were you taken to an emergency room? ☐no ☐yes. If yes, list the name and address of emergency room_____

Were x-rays taken? ☐no ☐yes Was any treatment or medication given? ☐no ☐yes. If yes, please list the treatment or medication

Since the accident, have you experienced any of the following (check all that apply)

☐memory loss/forgetfulness ☐loss of consciousness ☐moodiness ☐fatigue ☐headache ☐neck pain ☐difficulty swallowing

Other_____

Have you missed any days of work as result of this accident? ☐no ☐yes. If yes, list dates missed_____

Does your automobile insurance include payments for medical services? ☐no ☐yes. If yes, what is the name, address, telephone# and policy # of your insurance?_____

Have you retained an attorney to represent you? ☐no ☐yes. If yes, list his name, address, and telephone#_____

I certify that the information given above is true to the best of my knowledge.

Name Signature Date