MOTOR VEHICLE ACCIDENT REPORT

NAME:_____ PHONE #:_____

ADDRESS:_____ SOC. SEC. #:_____

CITY:_____ STATE:_____ ZIP:_____ BIRTHDATE: _____

Insured's Name (if not the patient):_____

Address:_____ City:_____ State:_____ Zip:_____

Insured's Birthdate:_____ Insured's Phone #:_____

MOTOR VEHICLE INSURANCE CO.:_____ PHONE #:_____

ADDRESS:_____ CITY:_____ STATE:_____ ZIP:_____

POLICY #:_____ CLAIM #:_____

CLAIM ADJUSTER'S NAME:_____ PHONE #:_____

Are you being represented by an attorney in this case? If yes:

ATTORNEY'S NAME:_____ PHONE #:_____

ADDRESS:_____ CITY:_____ STATE:_____ ZIP:_____

********** ********** ********** ********** ********** ********** **********

ACCIDENT DATE:_____ TIME:_____ STATE:_____DATES OFF WORK (if any):_____

Explain in detail how the accident happened:

Describe your symptoms/injuries in detail:

Have you seen other doctors for this injury?_____ If yes, list doctor's/clinic names and dates seen:

Have you had similar pain/symptoms before?_____ If yes, please explain (include doctors/clinics seen, and dates):

YOUR SIGNATURE_____ DATE:_____