ACCIDENTAL INJURY INFORMATION

Date of Accident Hour a.m. p.m. Location

How many vehicles were involved in the accident What position was your car

Where was your car impacted front rear left side right side

Where were you sitting in the car

Were you aware of the impending collision no yes

At the time of impact, how fast were the vehicles moving: yours other

How was your head positioned at the time of impact

Did your head hit anything during the accident no yes describe

Did you lose consciousness during the accident no yes how long

Did you have your seatbelt on at the time of impact no yes

Did you slide out of your seatbelt at any time during the accident no yes

Did you go to the hospital yes no If no, do not answer the following questions.

How did you get to the hospital ambulance I drove someone else drove

Which hospital did you go to How long were you there

What were you prescribed at the hospital:

Pain medication muscle relaxers brace nothing

Did you receive stitches yes no Where

Were x-rays taken yes no What body areas

Your Auto Insurance Company Adjuster

Name of Insured on Your Policy Relationship

Insurance Phone # Claim #

Do you have Personal Injury Protection (PIP) on your auto policy? yes no

Policy Limit

Uninsured Motorist Coverage Limit

Other driver’s insurance company

Other Driver’s Name and Phone #

Have you retained an attorney to represent you in this case? yes no

Attorney’s Name Phone #