

ACCIDENT WORKSHEET

Today's Date: _____ Referred by: _____

Date of Accident: _____ **Location of Accident:** _____

Brief Description of How Accident Happened: _____

INJURED PARTY'S NAME: _____

"AT-FAULT" DRIVER'S NAME: _____

"AT-FAULT" OWNER'S NAME: _____

BRIEF DESCRIPTION OF INJURIES (Areas of Body That Are Sore): _____

CLIENT INFORMATION:

Injured Party _____ Date of Birth _____ Age _____

Social Security #: _____ E-Mail: _____

Address _____ City/State: _____

Zip Code _____ Phone _____ (H) _____ (Cell) _____ (Wk) _____

Name/Address of Employer _____

Job Title/Description: _____

CLIENT'S SPOUSE / GUARDIAN INFORMATION:

Name of Spouse, Parent or Guardian _____ (_____)

(Relationship)

Home Address (if different) _____

Social Security #: _____ E-Mail: _____

Spouse's or Guardian's Employer _____ Phone _____

CLIENT'S CHILDREN:

	Name	D.O.B. (Age)	School / Grade	Occupation
1.				
2.				
3.				
4.				

ACCIDENT INFORMATION:

Date of Accident _____ Time _____ Location: _____

Weather Conditions: _____

Lanes of Traffic in Each Direction _____ Divided Roadway? Yes No.

Road Conditions (Dry/Wet/Slippery) _____

Accident report made Yes No. If so, CCR# _____

Any Statements by "At Fault" Driver: _____

Seat Belt worn Yes No Shoulder Harness worn Yes No

Were you: A Driver or A Passenger In Your Own Vehicle or In Another's Vehicle ? Or were you a Pedestrian ?

Names and Addresses of Witnesses to accident:

DEFENDANT INFORMATION:

Name of "At Fault" Driver _____

Address of "At Fault" Driver _____

Phone # of "At Fault" Driver _____ (H) _____ (Cell) _____ (Wk)

"At Fault" Driver's Insurance Company _____ Policy # _____

Claim # _____

Adjuster's Name, Address & Phone: _____

Name of **Owner(s)** of "At Fault" Vehicle _____

Address of "At Fault" **Owner(s)** _____

Phone # of "At Fault" **Owner(s)** _____

"At Fault" **Owners' Insurance Company** _____ Policy # _____

Claim # _____

Adjuster's Name & Phone: _____

INJURY INFORMATION:

<u>Current Injuries</u>	<u>Prior Injuries to Same Area From Any Source</u>	<u>Cause of Prior Injuries</u>
1.		
2.		
3.		
4.		
5.		

DID YOU GO TO THE EMERGENCY ROOM? Yes No

IF SO, WHEN? _____ WHERE? _____

WERE YOU ADMITTED INTO THE HOSPITAL? Yes No

IF SO, WHEN? _____ WHERE? _____

WHEN WERE YOU RELEASED? _____

NAME ALL DOCTORS SEEN FOR THIS ACCIDENT:

PRIOR ACCIDENTS

WHEN	WHERE	WHAT INJURED?	TREATED BY?	DATE OF LAST TREATMENT	FULL OR PARTIAL RECOVERY?

CAR INSURANCE:

FOR EACH MOTOR VEHICLE YOU OWN:

Make & Model (Year)	Insurance Company	Policy #	Claim #	PIP?	Uninsured Motorist Coverage?

PIP Adjuster: _____ PIP Claim #: _____ Phone #: _____

IF YOU DO NOT OWN A MOTOR VEHICLE:

Does anyone else in household own motor vehicles? Yes No

How many vehicles? _____ Describe: _____

FOR EACH MOTOR VEHICLE OWNED BY ANOTHER IN YOUR HOUSEHOLD:

Make & Model (Year)	Insurance Company	Policy #	Claim #	PIP?	Uninsured Motorist Coverage?

Whose vehicle were you driving? _____

Was this vehicle insured? If so, by whom _____

Named insured and policy # / claim # _____

HEALTH INSURANCE:

COMPANY	MEMBER NAME	I.D. #	GROUP #	HMO or PPO ?	PHONE #

CLIENT'S JOB INFORMATION:

Were you employed at time of accident? Yes No

Did you miss work? Yes No. If yes, how much? _____

Describe your duties _____

Rate Of Pay & How Paid (Hourly/Weekly/Monthly) _____

Were you on the job at time of accident? Yes No

VEHICLE DAMAGE INFORMATION:

How much damage to Vehicle you were in? _____

Was your Vehicle Towed? Yes No. _____

Name & Address of Where Towed: _____

Has it been repaired? Yes No. By whom ? _____

Were Photos Made? Yes No. By whom ? _____

PRIOR CLAIMS/LAWSUITS/WORKER COMPENSATION

Have you ever made a claim for damages? Yes No.

When, Where and for what injury or damage? _____

Have you ever made a worker's compensation claim? Yes No

If yes, describe: _____

PLEASE PROVIDE ALL INSURANCE CARDS, DRIVER EXCHANGE INFO,

ACCIDENT REPORT & DRIVER'S LICENSE FOR COPYING