NO FAULT INSURANCE INFORMATION

Patient Name: _____ Social Security #: _____

Claim #: _____

Date of Injury: _____/ _____/_____

Insurance Company Name: _____

Insurance Company Address: _____

Adjuster Name: _____

Adjuster Phone Number: _____

Attorney Name: _____

Attorney Phone Number: _____

Describe Accident:

_____

_____

_____

_____

What body part(s) did you report at the time of the accident?

_____

_____

Seat Belt: Yes ☐ No ☐ Accident Type: ☐ Rear ended ☐ Head-on ☐ Broad-sided

HISTORY OF THE PRESENT ILLNESS: (Mark a ✓ on each that applies to the accident if applicable)

Were you the: ☐ Driver ☐ Passenger

If passenger, where were you sitting: ☐ Front Seat ☐ Back Seat

Were you wearing your seatbelt: ☐ Yes ☐ No

Did the airbags deploy? ☐ Yes ☐ No Impending Collision

Were you: ☐ Aware ☐ Unaware ☐ Braced ☐ Not braced

Did your head: ☐ Strike Object ☐ Did Not Strike Object

☐ Break Glass

Did you experience: ☐ Shock ☐ Loss of Consciousness
☐ Whiplash ☐ Other

The weather conditions were: ☐ Sunny ☐ Raining ☐ Snowing ☐ Foggy

IMMEDIATELY FOLLOWING THE ACCIDENT: (Mark a ✓ on each that applies to the accident)

☐ Ambulance / Paramedics were called
☐ I was transported to Hospital by Ambulance
☐ I was treated at the Hospital
☐ I was treated at the scene
☐ I went to Hospital on my own
☐ Medication was prescribed

Which hospital? _____

What medications?_____

Is patient currently working? Yes_____ No _____. If no, last date worked: _____