AUTO ACCIDENT INTAKE FORM

Last Name _____ First Name _____ M._____

Birthdate_____ Phone (home)_____ Cell _____

Mailing Address _____ City _____ State _____ Zip_____

Date of accident _____ Time of accident _____am / pm

City and State of Accident _____ Did you have your seatbelt on? _____

Were you on the job at the time of the accident?_____ Was you the driver/passenger? _____

Were you in the front or back seat?_____ Did you lose consciousness upon impact? _____

Did the airbag deploy?_____ Was a police report filed?_____

Did you go to the hospital?_____ If so, which hospital? _____

Did you have x-rays? _____

Automobile Insurance Information

Driver of the automobile you were in:_____

Name of the insurance covering the vehicle you were in? _____

Policy # _____ Claim # _____

Insurance phone number _____ Name of adjustor _____

Driver of other automobile _____

Name of their insurance _____

Policy # _____ Claim # _____

Insurance phone number _____ Name of adjuster _____

List any symptoms below you have notice since the accident:

_____

_____

_____