Automobile Collision Report

NAME:_____ **DATE:** _____ / _____ / _____

DATE OF ACCIDENT: _____ / _____ / _____

Who is the policyholder of the car? _____

What is your relationship to the policyholder? _____

Insurance Co.: _____ ***Was the accident reported to the Insurance Co.?*** Yes No

Claim Adjuster's Name: _____ Claim#: _____

Address Of Insurance Company:_____

Phone: _____ Adjuster's Email: _____

Brief Description of the Accident: *Please use the back of this form, if necessary.*

_____

_____

_____

Location of Accident: _____ **Time:** _____ **:** _____ **am pm**

Were you a:

Driver Front Passenger Left Rear Passenger Middle Rear Passenger Right Rear Passenger
Pedestrian Bicyclist Motorcycle Rider Bus Passenger _____
Other: _____

Were you wearing a seatbelt? **Yes / No** Did your airbag deploy? **Yes / No** Headrest up? **Yes / No**

Point of Impact: _____ Number of Vehicles Involved: _____

Types of Vehicles: _____

Road Conditions: _____ Repair Costs *(If Known)*: $ _____

Did You See the Impact Coming? **Yes / No** Were You Able to Brace for the Impact? **Yes / No**
Was Your Head Straight at Impact? **Yes / No** If No, Head Position at Impact: **Right Left Down**
Did You Hit Any Body Parts in the Accident? **Yes / No** Where? _____
Did You Immediately Experience Pain? **Yes / No** Where? _____

Who Was at the Scene? **Police Ambulance Other:** _____
Did You Go to a Hospital After the Accident? **Yes / No** Where?_____
Tests Performed at the Hospital? **Yes / No** Which? _____
Medications Prescribed? **Yes / No** What? _____
Diagnosis Explained to You? **Yes / No** Explain: _____
Any Other Doctors Seen for this Injury? **Yes / No** Who? _____

Do you have an attorney? Yes No **Attorney's Name:** _____

Have you had any other car accidents, work injuries, or slip/falls within the past 5 years? Yes No

Signature: _____ **Date:** _____ / _____ / _____