



PERSONAL INJURY QUESTIONNAIRE

Please fill in all blanks.

Patient last name First name Middle initial Date of injury

Location of accident (including City and State)

Was the accident your fault? \_\_\_\_\_

Were you wearing a seatbelt? \_\_\_\_\_

Who was ticketed for this collision? \_\_\_\_\_ Please provide our office with a copy of the police report..

Did you go to the hospital? \_\_\_\_\_ If yes, via ambulance? \_\_\_\_\_

Were you admitted? \_\_\_\_\_ If yes, for how long? \_\_\_\_\_

Treatment rendered? \_\_\_\_\_

Area or body part injured \_\_\_\_\_

Have you seen a Doctor for this accident? \_\_\_\_\_ If yes, list the Doctor's seen. \_\_\_\_\_

Do you have Health Insurance? \_\_\_\_\_

Do you have an Attorney? \_\_\_\_\_ If so, provide all the information below.

Attorney name Attorney phone number ( ) -

Attorney address

Contact person's name

The following questions must be answered in full please:

Insurance Company name (Other car) Policy number Claim number

Insurance address City State Zip ( )

Policy holder's name (from card) Insurance Phone Number

Insurance company name (Your Car) Policy number Claim number

Insurance address City State Zip ( )

Policy holder's name (from card) Insurance Phone Number

Do you have med-pay coverage? \_\_\_\_\_ If so, how much \_\_\_\_\_

Have you informed your insurance company of this accident? \_\_\_\_\_ When \_\_\_\_\_

Explain how your injury happened in your own words:

Blank lines for explaining the injury.