skypoint
chiropractic

AUTO/WORKER'S COMP INSURANCE INFORMATION

Policy Holder Name:_____

Phone #_____

Auto/Workers Comp Insurance Name

_____

Phone # _____ **Fax:**_____

Address

_____

_____

Claim # _____

ID# /Group / Policy #_____

Adjuster's Name:_____

Adjuster's Phone #_____

Adjuster's Email:_____

Accident Information

1. Date of Accident:_____
2. What position where you in? □ Driver □ Middle Passenger □ Front Passenger □ Right Rear Passenger □ Middle Rear Passenger □ Left Rear Passenger
3. Time of Accident:_____ □ AM □ PM
4. Location of Accident: _____
5. Your Vehicle Speed: ____MPH (approximate) □ I don't know
6. Other Vehicle Speed: ____MPH (approximate) □ I don't know
7. What was the damage to your vehicle? □ Mild □ Moderate □ Extensive □ Totaled
8. What was the visibility? □ Poor □ Fair □ Good
9. What was the weather? □ Snowing □ Foggy □ Windy □ Clear □ Raining
10. Who hit what/who? □ You hit another vehicle □ Another vehicle hit you □ You hit an object
11. What was the point of impact? □ Front □ Rear □ Left Front □ Left Rear □ Left Side □ Right Front □ Right Rear □ Ride Side
12. Did you wear a seatbelt? □ Yes □ No
13. Did the seatbelt have a shoulder harness? □ Yes □ No
14. Does your vehicle have an airbag? □ Yes □ No
    a. Was the airbag deployed? □ Yes □ No
15. Did you strike anything on the vehicle? □ Yes □ No
    a. What did you strike? □ Wheel □ Dashboard □ Airbag □ Windshield □ Side Door □ Armrest □ Side Window □ Other:_____
    b. What body part was struck? _____

16. Did you see the accident coming? □ Yes □ No

17. Does your vehicle have headrests? □ Yes □ No

    a. What position are the headrests? □ Even with top of the head □ Even with the bottom of the head □ Middle of neck

18. Where you braced for impact? □ Yes □ No

19. Where you dazed? □ Yes □ No

20. Did you lose consciousness? □ Yes □ No

21. What was the direction of your head? □ Facing Forward □ Turned to Right □ Turned to Left

22. Was your head injured? □ Yes □ No

23. Was any other part of your body injured? □ Yes □ No

    If so, which part:_____

24. Immediately after accident did you experience: □ Headache □ Neck Pain □ Low Back Pain □ Other:_____

25. Did you go to the hospital? □ Yes □ No

    a. Which hospital did you go to? _____

    b. How did you get to the hospital? □ Ambulance □ Drove Self □ Someone Else □ Police □ Helicopter

    c. What tests were done at the hospital? □ X-Rays □ MRI □ CT Scan □ Lab Work □ Other_____

26. Any prior doctor for this accident? □ Yes □ No

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

Signature:_____ Date:_____