Auto Accident Form

Date______________________

Name____ Gender: ☐ Male ☐ Female D.O.B___/____/______

Your Social Security #________-_______-_________

No Fault Insurance Information

Your Claim # ____ Date of Accident _______/_______/________

Insurance Company______________________________________ Policy #______________________________

Address ____

Name of Adjustor ____ Phone (____)________-__________

Was the Accident in New York State? ☐ Yes ☐ No

Please explain how your accident happened: ____

____

____

____

____

Please answer the following questions:

1. Please circle your answer: Were you the driver or passenger? In the front seat or back seat?
2. Were you wearing a seat belt? Yes / No
3. Please circle your answer: Were you struck from behind or head on or side impact?
4. When and where did you feel any pain? ____
5. Did you go to the hospital? Yes / No
6. What treatment did you receive? ____
7. Did you have any xrays or MRI taken? Yes / No If yes, where? _______________________________________
8. Are your work activities restricted as a result of this accident? Yes / No
9. Since this injury, are your symptoms: Getting Worse, Getting Better, Staying the Same (circle one)
10. On a scale of 1-10 with 10 being the worst, how do you rate your pain today? _______________________

Signature: ____Date: ____/_____/_____