VEHICLE ACCIDENT INFORMATION

PATIENT INFORMATION

Date _____

Patient Name _____

Date of Accident _____ Time of Accident _____ ☐ a.m. ☐ p.m.

Please describe the accident in your own words: _____

_____

_____

_____

Were you the: ☐ Driver ☐ Front Passenger ☐ Rear Passenger ☐ Pedestrian

How many people were in the accident vehicle? _____

ACCIDENT SITE

Road/Street Name _____

City/State _____

Nearest intersection with road/street _____

Driving conditions ☐ Dry ☐ Wet ☐ Icy ☐ Other _____

Which direction were you headed? _____

Speed you were traveling? _____

VEHICLE

Make and model of vehicle you were in:

_____

Were you wearing a seatbelt? ☐ Yes ☐ No
If yes, what type? ☐ Lap ☐ Shoulder

Was vehicle equipped with airbags? ☐ Yes ☐ No
If yes, did it/they inflate properly? ☐ Yes ☐ No

Did your seat have a headrest? ☐ Yes ☐ No
If yes, what was the position of the headrest?
☐ Low ☐ Mid-position ☐ High

IMPACT

Did your car impact another vehicle? ☐ Yes ☐ No

Did your car impact a structure? ☐ Yes ☐ No

If yes, explain _____

_____

Did any part of your body strike anything in the vehicle?

☐ Yes ☐ No If yes, explain _____

Was impact from:

☐ Front ☐ Rear ☐ Left ☐ Right ☐ Other _____

At the time of impact were you:
☐ Looking straight ahead ☐ Looking to the right
☐ Looking to the left ☐ Looking down
☐ Looking up

Were both hands on the steering wheel? ☐ Yes ☐ No
If no, which hand was on the wheel? ☐ Right ☐ Left

Was your foot on the brake? ☐ Right ☐ Left
If yes, which foot was on the brake? ☐ Right ☐ Left

Were you: ☐ Surprised by impact ☐ Braced for impact

OTHER VEHICLE
(If applicable)

Make and model of other vehicle _____

Which direction was other vehicle headed? _____

Speed other vehicle was traveling? _____

OTHER VEHICLE

Did the police come to the accident site? ☐ Yes ☐ No
Were there any witnesses? ☐ Yes ☐ No
Was a police report filed? ☐ Yes ☐ No
Was a traffic violation issued? ☐ Yes ☐ No
If yes, to whom? _____

_____

PATIENT CONDITION

Were you unconscious immediately after the accident? ☐ Yes ☐ No If yes, for how long? _____

Please describe how you felt immediately after the accident:

_____

_____

_____

TREATMENT

Did you go to the hospital? ☐ Yes ☐ No
When did you go? ☐ Immediately after the accident ☐ Next Day ☐ 2 days or more after the accident
How did you get to the hospital? ☐ Ambulance ☐ Private transportation

Name of hospital _____ Name of doctor _____

Diagnosis _____

_____

Treatment received _____

_____

X-rays taken _____

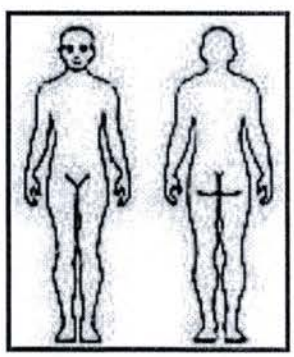
SYMPTOMS/INJURIES

Have you been able to work since this injury? ☐ Yes ☐ No How many work days have you missed? _____
Prior to the injury were you able to work on an equal basis with others your age? ☐ Yes ☐ No
If you have had any of the following symptoms since you injury, please ☑ check:

- ☐ Arm/shoulder pain
- ☐ Back pain
- ☐ Back stiffness
- ☐ Chest pain
- ☐ Dizziness
- ☐ Ear buzzing
- ☐ Ear ringing
- ☐ Fatigue
- ☐ Feet/toe numbness
- ☐ Hand/finger numbness
- ☐ Headaches
- ☐ Irritability
- ☐ Jaw problems
- ☐ Leg pain
- ☐ Memory loss
- ☐ Nausea
- ☐ Neck pain
- ☐ Neck stiff
- ☐ Shortness of breath
- ☐ Sleep difficulty
- ☐ Stomach upset
- ☐ Tension
- ☐ Vision blurred

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.



Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

Type of pain:
☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness
☐ Aching ☐ Shooting ☐ Burning ☐ Tingling
☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other _____

How often do you have this pain? _____

If the pain frequency ☐ Occasional ☐ Intermediate ☐ Frequent ☐ Constant

Does it interfere with your: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Activities or movements that are painful to perform: ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying down

I certify that the above information is correct to the best of my knowledge.

Patient Signature _____ Date _____

NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW
APPLICATION FOR MOTOR VEHICLE NO-FAULT BENEFITS

DATE	POLICY HOLDER	POLICY NUMBER	DATE OF ACCIDENT	CLAIM NUMBER
		N/A		

TO ENABLE US TO DETERMINE IF YOU ARE ENTITLED TO BENEFITS UNDER THE NEW YORK NO-FAULT LAW, PLEASE COMPLETE THIS FORM AND RETURN IT PROMPTLY.

IMPORTANT: 1. TO BE ELIGIBLE FOR BENEFITS YOU MUST COMPLETE AND SIGN THIS APPLICATION.
2. YOU MUST SIGN ANY ATTACHED AUTHORIZATION(S).
3. RETURN PROMPTLY WITH COPIES OF ANY BILLS YOU HAVE RECEIVED TO DATE.

NAME AND ADDRESS OF APPLICANT

1. YOUR NAME	2. PHONE NOS. HOME	BUSINESS
3. YOUR ADDRESS (NO., STREET, CITY OR TOWN AND ZIP CODE)	4. DATE OF BIRTH	5. SOCIAL SECURITY NO.
6. DATE AND TIME OF ACCIDENT A.M. P.M.	7. PLACE OF ACCIDENT (STREET), CITY OR TOWN AND STATE	
8. BRIEF DESCRIPTION OF ACCIDENT:		
9. DESCRIBE YOUR INJURY:		

10. IDENTITY OF VEHICLE YOU OCCUPIED OR OPERATED AT THE TIME OF ACCIDENT:

OWNER'S NAME MAKE YEAR

THIS VEHICLE WAS:

☐ A TRUCK, OR ☐ A BUS OR SCHOOL BUS
☐ A MOTORCYCLE ☐ AN AUTOMOBILE

11. WERE YOU THE DRIVER OF THE MOTOR VEHICLE? ☐ YES ☐ NO
WERE YOU A PASSENGER IN THE MOTOR VEHICLE? ☐ YES ☐ NO
WERE YOU A PEDESTRIAN? ☐ YES ☐ NO
WERE YOU A MEMBER OF OUR POLICYHOLDER'S HOUSEHOLD? ☐ YES ☐ NO
DO YOU OR A RELATIVE WITH WHOM YOU RESIDE OWN A MOTOR VEHICLE? ☐ YES ☐ NO

12. WERE YOU TREATED BY A DOCTOR(S) OR OTHER PERSON(S) FURNISHING HEALTH SERVICES? ☐ YES ☐ NO

NAME AND ADDRESS OF SUCH DOCTOR(S) OR PERSON(S):

13. IF YOU WERE TREATED AT A HOSPITAL(S), WERE YOU AN: OUT-PATIENT ☐ IN-PATIENT ☐

DATE OF ADMISSION: HOSPITAL'S NAME AND ADDRESS:

14. AMOUNT OF HEALTH BILLS TO DATE $ _____	15. WILL YOU HAVE MORE HEALTH TREATMENTS(S) ☐ YES ☐ NO	16. AT THE TIME OF YOUR ACCIDENT WERE YOU IN THE COURSE OF YOUR EMPLOYMENT? ☐ YES ☐ NO	
17. DID YOU LOSE TIME FROM WORK? ☐ YES ☐ NO	DATE ABSENCE FROM WORK BEGAN:	HAVE YOU RETURNED TO WORK? ☐ YES ☐ NO	IF YES, DATE RETURNED TO WORK:
AMOUNT OF TIME LOST FROM WORK:	18. WHAT ARE YOUR AVERAGE WEEKLY EARNINGS?	NUMBER OF DAYS YOU WORK PER WEEK:	NUMBER OF HOURS YOU WORK PER DAY:

19. WERE YOU RECEIVING UNEMPLOYMENT BENEFITS AT THE TIME OF THE ACCIDENT? ☐ YES ☐ NO

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BRACKETED LANGUAGE TO BE FILLED IN BY INSURER OR SELF-INSURER.

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