Spine & Pain Care

"Accident Details"

PLEASE FILL IN ONLY THE SECTION THAT APPLY AND SIGN THE BOTTOM.

SECTION NUMBER 5 MUST BE FILLED IN COMPLETELY IF THIS WAS NOT DUE TO AN ACCIDENT.

1. Describe how your injury occurred: _____

_____

_____

   B. The accident location was: _____

   C. Date of accident: _____

2. COMPLETE THIS SECTION IF YOUR INJURY WAS WORKRELATED:

   A. Were you on the job or was it related to work? YES NO

   B. If Yes. Employer Name: _____ Telephone # _____

   C. If yes, Did you report it to your employer? YES NO

3. COMPLETE THIS SECTION IF THERE WAS AN AUTO ACCIDENT:

   A. I was: a driver a passenger a pedestrian

   B. **MY** auto insurance company is: _____

   Adjustors Name: _____

   Insurance Company Phone # _____ Claim/Policy # _____

   C. Information on the OTHER DRIVERS:

   Name: _____ Telephone # _____

   Insurance Company: _____ Claim # _____

   Adjuster Name: _____ Telephone # _____

4. **DO YOU INTEND TO MAKE ANY CLAIMS:** YES NO

   A. Have you hired an attorney because of the accident? YES NO

5. **IF NONE OF THE ABOVE APPLY, PLEASE EXPLAIN:** _____

_____

_____

THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

Name: _____ Date: _____

Address: _____

Signature: _____ Date: _____