PERSONAL INJURY VERIFICATION
Medical payments/PIP/No-Fault

Patient: ______________________ Insured: ______________________

Policy#: ______________________ Claim # ______________________

Date of Injury: ______________________ Adjuster's name: ______________________

Relationship to Insured: (circle one) SELF FAMILY MEMBER OTHER

Has the accident been reported? YES NO Has a medical file been opened? YES NO

Medical limits: ______________________ What's left: ______________________

Benefits paid directly to doctor? YES NO If no, payable to patient and mailed to doctor? YES NO

Insurance Company Billing Address/Information

Name: ______________________

Address: ______________________

City, ST, ZIP ______________________

Phone: ______________________

Code: ______________________

Attorney Information

Attorney name: ______________________ Want bills? YES NO

Address: ______________________ Accept and honor lien: YES NO

City, ST, Zip: ______________________ Atty. Contact name: ______________________

Phone: ______________________

Fax: ______________________

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MOTOR VEHICLE COLLISION/PERSONAL INJURY QUESTIONNAIRE

Please answer all questions completely:

1. Your name and address:

 ____

 ____

 ____

2. Phone Number: ______________________

3. Please describe the collision in your own words:

 ____

 ____

 ____

4. Where did the collision occur? City/Town: ________________ State: ______
5. Date of collision: ________________ Time: ______________ AM PM
6. Were you the: ☐ driver ☐ passenger ☐ pedestrian
7. If passenger, were you in the ☐ front seat ☐ right rear seat ☐ left rear seat
8. What type of vehicle were you in? ______________________
9. What type was the other vehicle? ______________________
10. Did your vehicle strike the other vehicle? ☐ yes ☐ no
11. Was your car struck by the other vehicle? ☐ yes ☐ no
12. What direction was your vehicle going? ______________________
13. What direction was the other vehicle going? ______________________
14. Was the impact from: ☐ the front ☐ the rear ☐ the left side ☐ the right side
15. What was the approximate speed at the time of the impact?

 Your vehicle ________ mph Other vehicle ________ mph
16. What was the weather at the time of the collision? ☐ dry ☐ wet ☐ icy
17. Was your vehicle in: ☐ park ☐ neutral ☐ in gear ☐moving ☐stopped
18. Were your brakes being applied? ☐ yes ☐ no
19. Was your vehicle shoved: ☐ forward ☐ backward ☐ sideways
20. Were you shoved: ☐ forward ☐ whipped backward
21. Did your seat have a head restraint (headrest?) ☐ yes ☐ no

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22. If yes, what was the position ☐ low ☐ midposition ☐ high
23. Did your head ride over the headrest? ☐ yes ☐no
24. Did your hat/glasses end up in the back seat or rear window? ☐ yes ☐ no
25. Did any other part of your body hit the interior of the vehicle? ☐ yes ☐ no
26. If yes, please specify: ☐ seatbelt restraints ☐ steering wheel ☐ dashboard
☐ windshield ☐ side door ☐ side window. ☐ other ____________________
27. Which part of your body? ☐ chest ☐ head ☐ chin ☐ face ☐ R L knee
☐ R L shoulder ☐ R L hand ☐ other ______________________________
28. Were you holding on to the steering wheel? ☐ yes ☐ no
29. Did you brace your arms against the dash? ☐ yes ☐ no
30. Did you brace your legs against the floorboard? ☐ yes ☐ no
31. Was your ankle turned? ☐ yes ☐ no
32. Did the vehicle go into a spin or roll as a result of the impact? ☐ yes ☐ no
33. If yes, explain: ____
34. How much damage was there to the outside of the vehicle? ☐ none ☐ some ☐ a lot
35. How much damage was there to the inside of the vehicle? ☐ none ☐ some ☐ a lot
36. At the point of impact, where did you experience pain? Be specific:

____

____

37. Immediately after the accident were you: ☐ conscious ☐ dazed ☐ unconscious
38. If you lost consciousness, how long? ______________________________
39. Were you wearing a seat belt? ☐ yes ☐ no
40. Did the belt have a shoulder harness? ☐ yes ☐ no
41. If yes, did it contribute to the pain you are experiencing? ☐ yes ☐ no
42. At the time of impact were you: ☐ looking straight ahead ☐ looking to the right
☐ looking to the left ☐ looking down ☐looking up
43. Did the seat break as a result of the impact? ☐ yes ☐ no
44. Were you braced for the impact? ☐ yes ☐ no
45. Were you surprised by the impact? ☐ yes ☐ no
46. Did you go to the hospital? ☐ yes ☐ no
47. If yes, when? ☐ right after the accident ☐ next day ☐ other ______________

48. If yes, how did you get there? ☐ ambulance   other: ____________________

49. If by ambulance, did the ambulance attendants place you in a: ☐ neck brace
   ☐ back brace ☐ other ____________________

50. Any medication or medical supplies given? ____________________

51. Did you have x-rays taken at the hospital? ☐ yes ☐ no
   If you went to the hospital, please answer the following:
   Name of hospital ____________________
   Name of doctor ____________________
   Diagnosis ____________________
   Treatment Received ____________________
   ____

52. Have you had any similar problems before? ☐ yes ☐ no

53. If yes, explain: ____________________

54. Are you diabetic? ☐ yes ☐ no

55. Do you have high blood pressure? ☐ yes ☐ no

56. Do you have low blood pressure? ☐ yes ☐ no

57. Do you have arthritis or degenerative joint disease? ☐ yes ☐ no

58. What type of work do you do? ____________________

59. What are your job requirements? ____________________

60. Have you lost any days of work from this injury? ☐ yes ☐ no

61. If yes, give dates: ____________________

Patient Signature ____________________ Date __________

Witness ____________________ Date __________

Print Name ____________________

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PERSONAL INJURY INSURANCE COVERAGE

Date ____________________ Spoke With __________________ Number ____________

Patient Name ____

Insurance Company ____

Address ____

Phone Number ____

Insured Name ____

Date of Accident ____

Claim Number ____

Policy Number ____

Has the accident been reported? ☐ yes ☐ no

Name of adjuster handling claim ____

Will company accept assignment of benefits? ☐ yes ☐ no

If not, will they make checks payable to patient and our office? ☐ yes ☐ no

Limits: How much? $________________ What's left? __________________

GROUP HEALTH INSURANCE

Medical benefits under auto insurance? ☐ yes ☐ no

Insurance Company ____

Address ____

Phone Number ____

Insured Name ____

Agent _________________________ Policy# ________________ Phone ____________

Name and address of other party or parties involved in collision:

____

____

____

____

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ATTORNEY INFORMATION

Date ____________________ Spoke With __________________ Number ____________

Patient Name ____

Attorney Name ____

Address ____

Phone Number ____

Does attorney need copies of bills? ☐ yes ☐ no

In the event of settlement, will they protect any unpaid balance? ☐ yes ☐ no

Do they have PIP? ☐ yes ☐ no Do we file? ☐ yes ☐ no

Do they have insurance? ☐ yes ☐ no Do we file? ☐ yes ☐ no

Can we file liability? ☐ yes ☐ no

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