ACCIDENT REPORT

NAME: _____ Date: _____

Insurance Company: _____ Address: _____

Policy Number: _____ Employer: _____

Where did accident occur? _____

How did accident happen? _____

_____

How were you hurt? _____

_____

Were you unconscious? _____ Where were you taken after the accident? _____

What was done for you there? _____

Did you return to work? _____ If so, when and what type of work? _____

_____

How long were you off work? _____

Name of Physician: _____

What were you told was wrong with you? _____

What medications were you prescribed: _____

Are you still taking medication? _____ If so which medications: _____

Are you still receiving treatments? _____ If so what type: _____

Please list other doctors seen regarding the accident: _____

What are your present complaints? _____

_____

Have you ever had surgery? _____ If so, date(s) & conditions(s): _____

_____

Have you had any previous accidents? _____If so, how were you injured and what problems, if any, do you have as a result of those injuries? _____

_____

Any other comments: _____

_____