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MOUNT RAINIER CLINIC PLLC

Accident/ Injury Information

Date of Accident/Injury _____

Name _____

Your Insurance Company (PIP)

Other Vehicle Involved Ins. Co.

Name of Co _____

Name of Co _____

Ins. Address _____

Ins. Address _____

Ins. Phone# _____

Ins. Phone# _____

Adj. Phone# _____

Adj. Phone# _____

Name of Insured _____

Name of Insured _____

Claim# _____

Claim# _____

Policy# _____

Policy# _____

Attorney _____ **Phone#** _____

Address _____ **City/State** _____ **Zip** _____

Employer when injured _____ **Phone#** _____

In case of Emergency, who do we notify? _____
Phone# _____

I hereby give permission for any information requested by my insurance company acquired in the course of my examination and treatment. I also hereby authorize and direct my insurance benefits to be paid directly to the provider. I am financially responsible for non-covered services.

Signature _____ **Date** _____

I have read and agree to the above statements.

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Date of Accident _____ Hour _____ () AM () PM

Location _____

How did accident occur () Auto Collision () On the Job () Fall () Other

If not an Auto Accident, please describe circumstance _____

Did you report the injury/accident to (On Job) Foreman and/or Employer () Yes () No
(Auto) Police/Sheriff () Yes () No Insurance Co () Yes () No

If Auto Accident, were you () Driver () Passenger () Front Seat () Back Seat () Pedestrian

If Auto Accident, were you struck from () Behind () Right Side () Left Side () Front Side () Motorcycle

() Car Was Parked () Other _____

Did your car strike the other(s) involved () Yes () No -OR-

Did the other car strike you () Yes () No () Undetermined () _____

You were struck by (or struck) what type of vehicle _____

Did your body strike any part of the inside of the car () Yes () No, If yes describe _____

As a result of the accident were tickets issued to you () Yes () No, The driver of your car () Yes () No or the other driver () Yes () No

List your injuries _____

Were you hospitalized or taken to a hospital after the accident () Yes () No

Which Hospital _____ Doctor Seen _____

***Check symptoms you have noticed since the accident/injury:

- | | | | |
|-----------------------|----------------------------|------------------------|-------------------|
| () Headache | () Dizziness | () Light Bothers Eyes | () Diarrhea |
| () Neck Pain | () Head Seems Heavy | () Loss of Memory | () Feet Cold |
| () Neck Stiff | () Pins & Needles in Arms | () Ears Ring | () Hands Cold |
| () Sleeping Problems | () Pins & Needles in Legs | () Faced Flushed | () Stomach Upset |
| () Back pain | () Numbness in Fingers | () Buzzing in Ears | () Constipation |
| () Nervousness | () Numbness in Toes | () Loss of Balance | () Cold Sweats |
| () Tension | () Shortness of Breath | () Fainting | () Fever |
| () Irritability | () Fatigue | () Loss of Smell | () _____ |
| () Chest Pain | () Depression | () Loss of Taste | () _____ |

Symptoms other than above _____

Have you lost any days work () Yes () No Dates _____

() Lap Belt () Shoulder Harness Headrest - () Extended () Non-extended

Road Conditions () Ice () Dry () Wet () Snow

Speed at impact _____, Aware of Approaching Collision () Yes () No