Automotive Accident Form

Please take a moment to complete all the questions regarding your accident. Details are very important and are used in conjunction with the doctor's analysis and final care program.

Member Information

Full Name: ________________________________ Date of Birth:____________________

E-Mail Address:______________________________ SS#:__________________________

Mobile/Work Phone:___________________________ Home Phone:___________________

Name of Insured (check here if same as above ❑)

Full Name:___________________________ SS#:________________________

Home Address:_______________________________ Phone:_______________________

City:_______________________________________ State:____________Zip:_________

Auto Insurance

Your Carrier

Insurance Carrier:____________________________

Policy #____________________________________ Claim #______________________

Address:____________________________________ Phone:_______________________

City:_______________________________________ State:____________Zip:_________

Other Vehicle's Carrier

Insurance Carrier:____________________________ Claim #______________________

Phone:_________________________

Attorney Information (if applicable)

Have you retained an attorney? ❑ Yes ❑ No *If yes, please fill section below. Otherwise, continue to next section*

Attorney Name:_______________________________ Phone:_________________

Address:____________________________________

City:_______________________________________ State:____________Zip:_________

Accident Information (history of onset)

Date of Accident:______________________ Time of Accident: ❑ Morning ❑ Afternoon ❑ Dark

What position were you in the vehicle? ❑ Driver ❑ Front passenger ❑ Back seat passenger

Were you wearing a seat belt? ❑ Yes ❑ No Did your airbag deploy? ❑ Yes ❑ No

Did you hit any objects in the vehicle (i.e., door, dashboard, windshield) ? ❑ Yes ❑ No

If yes, what part of your body hit what object?____

What was your speed at impact?______________________What was their speed?_____________________

Who hit whom?____________________________________

Where was your vehicle's point of impact?____

What was the other vehicle's point of impact?____

What was the position of the head rests?____

Did you see the impact coming? ❑ Yes ❑ No If yes, did you brace for impact? ❑ Yes ❑ No

In what position was your body just prior to impact?____

What happened to your body at the moment of impact?____

What was your mental/emotional state immediately following the accident?__________________________

Did you receive medical attention at the scene of the accident? ❑ Yes ❑ No

Have you received any treatments prior to your visit at Wellcare? ❑ Yes ❑ No

If yes, where?_______________________________ Were X-rays/MRI/CT etc. taken?_____________

Please describe in detail how your accident occurred?____

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