

PERSONAL INJURY QUESTIONNAIRE

Name _____ Phone () _____

Address _____ City _____ State _____ Zip _____

Age _____ Birthdate _____ Sex _____ S/S # _____

Employer's Name _____ Employer's Address _____

Your Ins. Co. _____ Policy # _____ Agent's Name _____

Name on Policy (If other than self) _____ Policy # _____

Responsible Party's Name _____

Address _____ City _____ State _____ Zip _____

Policy Holder's Name _____ Policy # _____

ATTORNEY

Name _____ Phone () _____

Address _____ City _____ State _____ Zip _____

Were there any witnesses? () Yes () No Name(s) _____

NATURE OF ACCIDENT:

1. Date of Accident _____ Time of Day _____

2. Were you: () Driver () Passenger () Front Seat () Back Seat

3. Number of people in your vehicle? _____ Were you wearing seat belts? _____

4. What direction were you headed? () North () East () South () West
on (name of street) _____

5. What direction was other vehicle headed? () North () East () South () West
on (name of street) _____

6. Were you struck from: () Behind () Front () Left side () Right side

7. Approximate speed of your car _____ mph Other car _____ mph

8. Were you knocked unconscious? () Yes () No If yes, for how long? _____

9. Were police notified? () Yes () No

10. In your own words, please describe accident: _____

11. Did you have any physical complaints BEFORE THE ACCIDENT? () Yes () No If yes, please describe in detail: _____

12. Please describe how you felt:

a. DURING the accident: _____

b. IMMEDIATELY AFTER the accident: _____

c. LATER THAT DAY: _____

d. THE NEXT DAY: _____

13. What are your PRESENT complaints and symptoms? _____

14. Do you have any congenital (from birth) factors which relate to this problem? () Yes () No If yes, please describe:

15. Do you have any previous illnesses which relate to this case? () Yes () No If yes, please describe:

16. Have you ever been involved in an accident before? () Yes () No If yes, please describe, including date(s) and type(s) of accidents, as well as injury(ies) received. _____

17. Where were you taken after the accident? _____

18. Have you been treated by another doctor since the accident? () Yes () No If yes, please list doctor's name and address: _____

What type of treatment did you receive? _____

19. Since this injury occurred, are your symptoms: () Improving () Getting Worse () Same

20. CHECK SYMPTOMS YOU HAVE NOTICED SINCE ACCIDENT:

- | | | | | |
|--|---|--|--|--|
| <input type="checkbox"/> Headache | <input type="checkbox"/> Irritability | <input type="checkbox"/> Numbness in Toes | <input type="checkbox"/> Face Flushed | <input type="checkbox"/> Feet Cold |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Buzzing in Ears | <input type="checkbox"/> Hands Cold |
| <input type="checkbox"/> Neck Stiff | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Stomach Upset |
| <input type="checkbox"/> Sleeping Problems | <input type="checkbox"/> Head Seems Too Heavy | <input type="checkbox"/> Depression | <input type="checkbox"/> Fainting | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Pins & Needles in Arms | <input type="checkbox"/> Lights Bother Eyes | <input type="checkbox"/> Loss of Smell | <input type="checkbox"/> Cold Sweats |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Pins & Needles in Legs | <input type="checkbox"/> Loss of Memory | <input type="checkbox"/> Loss of Taste | <input type="checkbox"/> Fever |
| <input type="checkbox"/> Tension | <input type="checkbox"/> Numbness in Fingers | <input type="checkbox"/> Ears Ring | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> _____ |

Symptoms Other Than Above _____

21. Have you lost time from work as a result of this accident? () Yes () No If yes, please complete this question.

a. Last Day Worked: _____

b. Type of Employment: _____

c. Present Salary: _____

d. Are you being compensated for time lost from work? () Yes () No If yes, please state type of compensation you are receiving: _____

22. Do you notice any activity restrictions as a result of this injury? () Yes () No If yes, please describe, in detail:

23. Other pertinent information: _____

DATE

PATIENT'S SIGNATURE

**NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW
APPLICATION FOR MOTOR VEHICLE NO-FAULT BENEFITS**

NAME AND ADDRESS OF INSURER *	NAME, ADDRESS, AND PHONE NUMBER OF INSURER'S CLAIMS REPRESENTATIVE*
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DATE	POLICYHOLDER	POLICY NUMBER	DATE OF ACCIDENT	CLAIM NUMBER
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TO ENABLE US TO DETERMINE IF YOU ARE ENTITLED TO BENEFITS UNDER THE NEW YORK NO-FAULT LAW, PLEASE COMPLETE THIS FORM AND RETURN IT PROMPTLY.

- IMPORTANT:** 1. TO BE ELIGIBLE FOR BENEFITS YOU MUST COMPLETE AND SIGN THIS APPLICATION.
 2. YOU MUST SIGN ANY ATTACHED AUTHORIZATION(S).
 3. RETURN PROMPTLY WITH COPIES OF ANY BILLS YOU HAVE RECEIVED TO DATE.

NAME AND ADDRESS OF APPLICANT*

1. YOUR NAME	2. PHONE NOS.	HOME	BUSINESS
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3. YOUR ADDRESS (NO., STREET, CITY OR TOWN AND ZIP CODE)	4. DATE OF BIRTH	5. SOCIAL SECURITY NO.
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6. DATE AND TIME OF ACCIDENT A.M. P.M.	7. PLACE OF ACCIDENT (STREET), CITY OR TOWN AND STATE
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8. BRIEF DESCRIPTION OF ACCIDENT

9. DESCRIBE YOUR INJURY

10. IDENTITY OF VEHICLE YOU OCCUPIED OR OPERATED AT THE TIME OF THE ACCIDENT:

OWNER'S NAME MAKE YEAR

THIS VEHICLE WAS: A BUS OR SCHOOL BUS, A TRUCK, AN AUTOMOBILE,
 OR A MOTORCYCLE

	YES	NO
11. WERE YOU THE DRIVER OF THE MOTOR VEHICLE?	<input type="checkbox"/>	<input type="checkbox"/>
WERE YOU A PASSENGER IN THE MOTOR VEHICLE?	<input type="checkbox"/>	<input type="checkbox"/>
WERE YOU A PEDESTRIAN?	<input type="checkbox"/>	<input type="checkbox"/>
WERE YOU A MEMBER OF OUR POLICYHOLDER'S HOUSEHOLD?	<input type="checkbox"/>	<input type="checkbox"/>
DO YOU OR A RELATIVE WITH WHOM YOU RESIDE OWN A MOTOR VEHICLE?	<input type="checkbox"/>	<input type="checkbox"/>

CONTINUATION ON NEXT PAGE

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12. WERE YOU TREATED BY A DOCTOR(S) OR OTHER PERSON(S) FURNISHING HEALTH SERVICES?

YES NO

IF YES, NAME AND ADDRESS OF SUCH DOCTOR(S) OR PERSON(S):

13. IF YOU WERE TREATED AT A HOSPITAL(S), WERE YOU AN

OUT-PATIENT? IN-PATIENT?

DATE OF ADMISSION: _____

HOSPITAL'S NAME AND ADDRESS: _____

14. AMOUNT OF HEALTH
BILLS TO DATE:

\$ _____

15. WILL YOU HAVE MORE HEALTH
TREATMENT(S)?

YES NO

16. AT THE TIME OF YOUR ACCIDENT WERE
YOU IN THE COURSE OF YOUR
EMPLOYMENT?

YES NO

17. DID YOU LOSE TIME
FROM WORK?

YES NO

DATE ABSENCE FROM
WORK BEGAN:

HAVE YOU RETURNED TO
WORK?

YES NO

IF YES, DATE RETURNED TO WORK: _____

AMOUNT OF TIME LOST FROM WORK: _____

18. WHAT ARE YOUR GROSS AVERAGE
WEEKLY EARNINGS?

NUMBER OF DAYS YOU WORK
PER WEEK:

NUMBER OF HOURS YOU WORK
PER DAY:

19. WERE YOU RECEIVING UNEMPLOYMENT BENEFITS AT THE TIME OF THE ACCIDENT?

YES NO

20. LIST NAMES AND ADDRESS OF YOUR EMPLOYER AND OTHER EMPLOYERS FOR ONE YEAR PRIOR TO
ACCIDENT DATE AND GIVE OCCUPATION AND DATES OF EMPLOYMENT:

EMPLOYER AND ADDRESS	OCCUPATION	FROM	TO

21. AS A RESULT OF YOUR INJURY HAVE YOU HAD ANY OTHER EXPENSES?

YES NO

IF YES, ATTACH EXPLANATION AND AMOUNTS OF SUCH EXPENSES.

22. DUE TO THIS ACCIDENT HAVE YOU RECEIVED OR ARE YOU ELIGIBLE FOR PAYMENTS
UNDER ANY OF THE FOLLOWING:

NEW YORK STATE DISABILITY? YES NO

WORKERS' COMPENSATION?

CONTINUATION ON NEXT PAGE