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BCA BELLEVUE CHIROPRACTIC ASSOCIATES

# AUTO ACCIDENT REPORT

Name _____ Date of Accident _____

Please describe or sketch the accident:

Year/make/model of your car: _____
Total # cars involved: _____
Est. speed of your car: _____
Est. speed of other car: _____
Were you: Driver | passenger
Road conditions were: _____
Did you hit anything on the inside of the car? _____
Were you knocked *unconscious* or *dazed*? (circle answer)
For how long? _____
Describe your head position at the time of the impact:

_____

Have you been examined/treated since the accident
(Hospital ER, Dr., etc)? _____
Was an accident report made? _____
Est. of auto damage: $ _____
Was your car drivable? _____

Year/make/model of other car: _____
Were you hit from: Front | Back | Right side | Left side
Were your brakes applied? ☐ Yes ☐ No
Was your car: automatic | manual transmission
Were you wearing: lap belt | shoulder belt
Were you aware of the impending collision?
☐ Yes ☐ No
Were there:
☐ Multiple vehicular impacts
☐ Impacts with road barriers (poles, trees, barriers, etc.)
Did you notice any bruising/swelling? _____
Where? _____
Have you lost work time as a result of your injuries? _____
How much? _____
Have you had any previous accidents resulting in injury
treatment? _____

## YOUR AUTO INSURANCE

Insurance Company _____
Address _____
City _____ State _____ Zip _____
Phone Number _____
Claim Number _____
Insured _____
Adjuster's Name _____

## HEALTH INSURANCE

Insurance Company _____
Address _____
City _____ State _____ Zip _____
Phone Number _____
Identification Number _____
Group Number _____
Subscriber's Name _____

## OTHER PARTY'S AUTO INSURANCE

Insurance Company _____
Address _____
City _____ State _____ Zip _____
Phone Number _____
Claim Number _____
Insured _____
Adjuster's Name _____

## ATTORNEY

Has an attorney advised you in this matter? _____
Are you being represented? _____
Attorney Name _____
Address _____
City _____ State _____ Zip _____
Phone Number _____