Wieging Physical Medicine, LLC

AUTOMOBILE INJURY FORM

NAME_____ DATE_____

Date of Accident_____ Time: ___am ___pm Location of Accident_____

AUTO INJURY

Were You: ( ) Driver ( ) Passenger ( ) Pedestrian

Were you struck from: ( ) Behind ( ) Right Side ( ) Left Side

Did your car strike the others involved: ( ) Yes ( ) No

Did the other car strike yours: ( ) Yes ( ) No

As a result of the Accident, were you cited? ( ) Yes ( ) No

IN YOUR OWN WORDS DESCRIBE WHAT HAPPENED

_____

_____

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INSURANCE INFORMATION

****It is our policy to bill the medical payments (med-pay) portion of <u>your</u> automobile insurance policy for services rendered. Once your med-pay has reached the maximum amount payable, we will then submit remaining charges to the 3rd party carrier, and await settlement of your claim****

Your Automobile Insurance Company_____ Phone# _____

Claim # _____ Adjuster_____

Other Party's Name_____

Other Party's Ins. Co._____Phone # _____ Claim # _____

Have you been contacted by an insurance adjuster regarding this claim ( ) Yes ( ) No

If yes, name of adjuster_____Company_____

Do you have an attorney that has advised you in this case: ( ) Yes ( ) No

If yes, attorney's name_____Phone # _____

Signature_____

AUTOMOBILE INJURY FORM pg 2

NAME_____ACCT.#_____

CHECK SYMPTOMS YOU HAVE NOTICED SINCE THE ACCIDENT

( ) Headache	( ) Sleeping Problems	( ) Lights Bother Eyes	( ) Diarrhea
( ) Neck Pain	( ) Head Too Heavy	( ) Loss of Memory	( ) Feet Cold
( ) Neck Stiff	( ) Pins & Needles in Arms	( ) Ears Ringing	( ) Hands Cold
( ) Dizziness	( ) Pins & Needles in Legs	( ) Face 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	( ) Other
( ) Chest Pain	( ) Depression	( ) Loss of Taste	_____

Additional Symptoms/Complaints:

_____

_____

Did you strike anything at the time of impact? ( ) Yes ( )No

If yes, specify what part of your body struck what: ie....head,chest,chin,knee right/left...

Steering wheel_____ Dashboard_____

Windshield_____ Roof_____

Door_____ Window_____

Seat/headrest_____ Other_____

Did you brace for impact? ( ) Yes ( ) No ____I used my hands___I used my feet

Where you wearing your seatbelt? ( ) Yes ( )No

Did you require post-accident hospitalization? ( ) Yes If yes, how long ___days ( ) No

Have you lost any days of work? ( ) Yes ( ) No If Yes (dates) _____

Have you seen any other physicians as a result of this accident? ___Yes___No

Doctor's name:_____Phone:_____

Address:_____

At any time did you lose consciousness ( ) Yes ( ) No

Immediately following the accident, how did you feel? ____Dizzy/Dazed ___Disoriented___Upset ___Nervous___Nauseous ___Weak ____Other_____

Signature_____