Personal Injury Questionnaire

Name: _____ Date of Birth: _____ Date: _____

Your Insurance Company: _____ Policy Number: _____

Agent's Name: _____

Other Insurance Company: _____

Policy Number: _____

Have you retained an attorney? ☐ Yes ☐ No Attorney's Name: _____

1. Date of accident: _____ Time of Day: _____ ☐ AM ☐ PM
2. Were you: ☐ Driver ☐ Passenger ☐ Front Seat ☐ Back Seat
3. Number of people in the vehicle: _____ Number of people in other vehicle: _____
4. Road conditions at time of accident: ☐ Wet ☐ Dry ☐ Icy ☐ Other: _____
5. Were you struck from: ☐ Behind ☐ Front ☐ Left Side ☐ Right Side
6. Were you wearing a seat belt? ☐ Yes ☐ No
   If **Yes**: ☐ Lap Belt Only ☐ Shoulder and Lap Belt ☐ Shoulder Belt Only
7. Did you sustain any bruising or soreness from the seatbelt? ☐ Yes ☐ No
   If **Yes**, Explain: _____
8. What was your position at the time of impact? ☐ Facing forward ☐ Head turned ☐ Left Side ☐ Right Side
9. Does your car have a headrest? ☐ Yes ☐ No If **Yes**, approximately how far was the top of the headrest from the top of your head? _____ Inches ☐ Above ☐ Below
10. Were you knocked unconscious? ☐ Yes ☐ No If **Yes**, for how long? _____
11. Were you aware of the approaching collision prior to impact? ☐ Yes ☐ No
12. Was your car stopped at the time of impact? ☐ Yes ☐ No
    If **Yes**: Was the driver's foot on the brake pedal? ☐ Yes ☐ No
    Did your car move forward upon impact? ☐ Yes ☐ No
    If **No**: Were you: ☐ Gaining speed ☐ Slowing down ☐ Traveling the speed limit ☐ Driving Slow ☐ Driving Fast
13. Did your vehicle strike another vehicle? ☐ Yes ☐ No
14. Did your vehicle strike another object? ☐ Yes ☐ No If **Yes**, what? _____
15. Was the other vehicle moving at the time of the collision? ☐ Yes ☐ No
    If **Yes**, was the vehicle was traveling ☐ Slow ☐ Medium ☐ Fast
    And ☐ Gaining speed ☐ Slowing down ☐ Traveling steadily
16. Make and Model of your vehicle: _____
17. Make and Model of other vehicle: _____
18. Describe the accident, including what you saw, heard and/or felt: _____
19. Describe how you felt: _____
20. Did you feel pain? ☐ Yes ☐ No If **Yes**, what? _____
    During the accident: _____
    Immediately after the accident: _____
    Later that day: _____
    The next day: _____
21. What is the estimated cost of damage to your vehicle: _____
    Do you have photos of the damage? ☐ Yes ☐ No

(Please See Reverse Side)

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22. On what part of the automobile did the following body parts hit:

Head	_____	Right / Left Arm	_____
Chest	_____	Right / Left Leg	_____
Right / Left Hip	_____	Right / Left Knee	_____
Right / Left Shoulder	_____	Other:	_____

23. Did the air bag(s) deploy ☐ Yes ☐ No If **Yes**, what part of your body hit the air bag? _____

24. Did it leave a bruise? ☐ Yes ☐ No

25. Which of the following car parts broke during the accident: ☐ Windshield ☐ Right / Left Side Window
☐ Steering Wheel ☐ Front / Back Seat ☐ Other(s): _____

26. Did you have any physical complaints BEFORE THE ACCIDENT? ☐ Yes ☐ No
If **Yes**, describe in detail _____

27. What are your PRESENT complaints and symptoms? _____

28. Do you have any congenital (from birth) factor(s) which relates to this problem? ☐ Yes ☐ No
If **Yes**, describe in detail _____

29. Do you have any previous illnesses relating to this case? ☐ Yes ☐ No
If **Yes**, describe in detail _____

30. Have you ever been involved in an accident before? ☐ Yes ☐ No
If **Yes**, please describe _____

31. Did you receive any medical care following the accident? ☐ Yes ☐ No
If **Yes**, where, what type of treatment, and doctor's name: _____

32. Have you been treated by another doctor since the accident? ☐ Yes ☐ No
If **Yes**, list doctor's name and contact info: _____

What type of treatment did you receive? _____

33. Since this injury occurred, are your symptoms: ☐ Improving ☐ Getting Worse ☐ Same

34. CHECK SYMPTOMS THAT YOU HAVE NOTICED SINCE THE ACCIDENT (Check all that apply):

☐ Arm Pain	☐ Dizziness	☐ Emotions out of control	☐ Loss of Taste	☐ Pins & Needles in Arms
☐ Bright Light Sensitivity	☐ Ears Ring	☐ Head seems too Heavy	☐ Low Back Pain	☐ Pins & Needles in Legs
☐ Chest Pain	☐ Elbow Pain	☐ Hip Pain	☐ Mid Back Pain	☐ Shortness of Breath
☐ Cold Feet	☐ Face Flushed	☐ Irritability	☐ Neck Pain	☐ Shoulder Pain
☐ Cold Hands	☐ Fainting	☐ Knee Pain	☐ Neck Stiffness	☐ Sleeping Problems
☐ Cold Sweats	☐ Fatigue	☐ Leg Pain	☐ Nervousness	☐ Upper Back Pain
☐ Constipation	☐ Fever	☐ Loss of Balance	☐ Numbness in Fingers	☐ Wrist Pain
☐ Depression	☐ Foot Pain	☐ Loss of Memory	☐ Numbness in Toes	
☐ Diarrhea	☐ Headache	☐ Loss of Smell	☐ Other:	

35. Employer: _____ Type of Employment: _____

36. Have you lost time from work as a result of this accident? ☐ Yes ☐ No
If **Yes**, when was the last day worked? _____ # of days missed: _____
If **Yes**, are you being compensated for time lost from work? ☐ Yes ☐ No
If **Yes**, type of compensation you are receiving: _____

37. Do you notice any activity restrictions in your capacity for work, family or recreational pursuits as a result of this injury?
☐ Yes ☐ No If **Yes**, describe in detail _____

38. Other pertinent information: _____

Personal Injury Protection (PIP) Billing

What is PIP?

- Personal Injury Protection is a part of your auto insurance policy. It is designed to take care of you immediately after an accident.
- If you have PIP, you MUST use it. Your health insurance will not cover your expenses if you have PIP.
- If you were not the "at-fault" party, your PIP will be reimbursed by the 3rd party.

Benefits of PIP

- PIP is no-fault, so it doesn't matter who caused the accident…you're still covered.
- Most PIP coverage is for 3-years or $10,000, whichever comes first. Some policies have higher limits.
- PIP covers medical payments, wage loss and loss of services.
- There is no deductible. There are no co-pays.

What is Med Pay?

- Med Pay is a medical-payments only version of PIP. It does not cover wage loss or loss of services.

A Step-By-Step Guide

1. Call YOUR insurance agent. Ask if you have PIP or Med Pay.
2. If "NO", ask for a copy of the document you signed waiving PIP benefits.
3. If yes, ask about limits on time and dollar amount.
4. Ask your agent to take your report of loss and call it into the claims office.
5. Ask your agent to call back with the claim number, address and phone of the claims office.
6. Call the claims office and get the name of the claims adjuster handling your claim.
7. Ask the claims adjuster to mail a PIP Application, Attending Physician's Report, and Salary Verification forms.
8. Complete the PIP Application and return it to the claims adjuster.
9. Have your chiropractor fill out the Attending Physician's report form and return it to you and mail it to your claims adjuster.
10. Have your employer complete the Salary Verification form and return it to you and mail it to your claims adjuster.
11. Provide your claim number, adjustor's name, office address and phone number in the space provided below.

Name of YOUR Insurance Company: _____

Insurance Company's Address: _____

City: _____ State: _____ Zip: _____

Claim Number: _____ Phone: _____

Adjuster's Name: _____ Phone: _____

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