NAME OF FACILITY

ADDRESS OF FACILITY

PLEASE PRINT LEGIBLY

PT. NAME MAILING ADDRESS

CITY STATE ZIP

D.O.B SEX MARITAL STATUS SS#

HOME TEL# ACCIDENT TYPE AUTO WORK OTHER

CELL# D.O.A PLACE OF ACCIDENT

DESCRIBE YOUR INJURIES

- ☐ HEADACHES
- ☐ NECK
- ☐ BACK
- ☐ OTHER

☐ DRIVER ☐ PASSENGER ☐ PEDESTRIAN ☐ OTHER

FOR FEMALE PATIENTS ONLY: ARE YOU PREGNANT? ☐ Yes ☐ No

PT. EMPLOYER PHONE #

OCCUPATION ☐ FULL / ☐ PART DRIVER LIC#

PT. EMPLOYER'S ADDRESS

EMERGENCY TEL. # NAME

Is there a Law Suite pending on your accident of injury? ☐ Yes ☐ No

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NAME OF ATTORNEY

(Last) (First)

ATTORNEY PHONE #

HEALTH INSURANCE PLAN PHONE

AUTO INSURANCE PHONE

WORKING COMP. INS PHONE

WHO REFERRED YOU TO OUR OFFICE: ☐ ATTORNEY ☐ FRIEND ☐ OTHER

I, THE UNDERSIGNED, CERTIFY THAT THE FOLLOWING IS TRUE AND CORRECT

DATE SIGNATURE

NAME OF FACILITY

ADDRESS OF FACILITY

PATIENT QUESTIONAIRE

NAME

(Last) (First)

Date of Accident

(Month) (Day) (Year)

1.At the time of the accident I was the

2.Were you injured?

3.List the dates of all prior automobile accidents that you were involved in in for the last 3 years and circumstances surrounding each of the accidents.

4.What is your relationship to the other passengers in the vehicle that you were in?

5.Did you know anyone from the other vehicle(s) involved in the accident?

- If yes, please specify whom

6.Was this accident staged?

- Please be advised that New York State law prohibits the filing of a fraudulent claim, which is a crime punishable by imprisonment.

Print Name SS#

Signature Date