MVA

IF YOUR INJURY IS RELATED TO A MOTOR VEHICLE ACCIDENT, PLEASE COMPLETE THE FOLLOWING QUESTIONS:

DATE OF ACCIDENT:________________ TIME: ___________________ ☐AM☐ PM LOCATION: ______________________________
CAR INSURANCE COMPANY: _____________________ ADDRESS: ____
PHONE #: __________________FAX #: _____________________CLAIM # (If known): ______________________________
NAME OF ADJUDICATOR ASSIGNED TO YOU? (If known): ____
HAVE YOU REPORTED THE ACCIDENT TO YOUR INSURANCE COMPANY? ☐NO ☐YES
DO YOU HAVE EXTENDED HEALTH INSURANCE? (ie. From work): ☐NO ☐YES: Name of Company: __________________
Policy #: _______________________________ Phone #: ________________________

PLEASE DESCRIBE WHAT HAPPENED: ____

WHAT SYMPTOMS HAVE YOU NOTICED SINCE THE ACCIDENT? ____

DID YOU SUFFER FROM ANY PAIN PRIOR TO THE ACCIDENT? : ☐NO ☐YES: Where? ________________________________

WHAT LIMITATIONS HAVE YOU NOTICED SINCE THE ACCIDENT?

☐CAN'T CLEAN	☐CAN'T LIFT	☐CAN'T STUDY
☐CAN'T COOK	☐CAN'T LOOK AFTER CHILDREN	☐OTHER: ____________________
☐CAN'T SIT FOR LONG	☐CAN'T CONCENTRATE	☐OTHER: ____________________
☐CAN'T WORK	☐CAN'T STAND FOR LONG	☐OTHER: ____________________

WERE YOU EMPLOYED AT THE TIME OF THE ACCIDENT? ☐NO ☐YES: WHERE? ________________________ POSITION: _______________

HAVE YOU LOST ANY DAYS FROM WORK? ☐NO ☐YES: List Dates: __________________________________
CAN WE CONTACT YOUR EMPLOYER? ☐NO ☐YES: Contact Name: ______________ Phone #: _______________ Email: ________________

WERE YOU ATTENDING SCHOOL AT THE TIME OF THE ACCDIENT? ☐NO ☐YES: Did you miss any school as a result? ☐NO ☐YES

DO YOU HAVE ANY DEPENDANTS? ☐NO ☐YES: Names and Ages: ____

DO YOU HAVE AN ATTORNEY WHO HAS ADVISED YOU IN THIS CASE? ☐NO ☐YES: Name: _______________ Phone #: _______________

DAMAGE TO YOUR CAR: $__________________ OTHER VEHICLE (If applicable): $________________

WHERE YOU THE: ☐DRIVER ☐PASSENGER ☐REAR DRIVERS SIDE ☐REAR PASSENGERS SIDE ☐ PEDESTRIAN ☐ A CYCLIST

ANY OTHER PERSONS IN THE CAR? ☐NO ☐YES: Are they injured? ☐NO ☐YES

HOW WERE YOU STRUCK ? (Check all that apply) ☐REAR-ENDED ☐SIDE/T-BONED ☐HEAD ON ☐LEFT SIDE ☐RIGHT SIDE

YOUR CAR MODEL: _____________Speed at impact: ___ km/hr CAR MODEL THAT HIT YOU: _____________ Speed at impact: ___ km/hr

DID YOU SUFFER FROM: A LOSS OF CONSCIOUSNESS? ☐NO ☐YES, AMNESIA? ☐NO ☐YES

DID YOU GO TO THE HOSPITAL AS A RESULT OF THE ACCIDENT? ☐NO ☐YES: Did you require an ambulance to get to the hospital? ☐NO ☐ YES, Which Hospital? _________________________________ Doctor's Name? ________________________
How long did you stay? ______________________________ X-rays taken? ☐NO ☐YES: Results: _____________________________

HAVE YOU VISITED A MEDICAL DOCTOR SINCE THE ACCIDENT? ☐NO ☐YES: Name of Doctor: ______________________

ANY INVESTIGATION OR PRESCRIPTIONS? ☐NO ☐YES: ____

WERE YOU WEARING YOUR SEATBELT? ☐NO ☐YES – AIR BAGS DEPLOYED? ☐NO ☐YES

PLEASE READ AND SIGN THE FOLLOWING:
The above statements are true to the best of my knowledge.
If for any reason the insurance will not accept or discontinue my claim, I am responsible for all charges.

Signature: _______________________________ Date: ____