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MOTOR VEHICLE ACCIDENT INTAKE FORM

FOR OFFICE USE ONLY

TODAY'S DATE:

DATE OF THE ACCIDENT:

INTERVIEWED BY:

REFFERRED BY:

Please provide reception with two forms of identification; a copy of the collision report; a copy of your motor vehicle insurance; and copies of any documents you received from the insurance company.

Full Name: ________________________________

Address: ________________
____

Home Phone: _____________________ Work Phone: _____________________

Cell: Phone _____________________ Email: _____________________

Preferred method of communication: ☐Home Phone ☐Cell Phone ☐ email

Personal Information

Driver's License Number : ____

Social Insurance Number: ____

OHIP Number: ____

Marital Status: ☐Single ☐ Married ☐ Common Law ☐ Separated

Number of Children: __________

Name: ___________________________Date of Birth (dd/mm/yy) __________

Name: ___________________________Date of Birth (dd/mm/yy) __________

Name: ___________________________Date of Birth (dd/mm/yy) __________

Your Auto Insurance Information

If you do not have insurance, but someone in your house does, provide their information

Insurance Company: ______________________________

Name of Insured: ______________________________

Relationship to you: ______________________________

Policy Number: ______________________________

Have you already made a claim to your insurance company? ☐ Yes ☐ No

Claim Number: ______________________________

Adjuster's Name ______________________________

Telephone Number ______________________________

Other Insurance Coverage

Do you or your family have any other type of medical or disability coverage such as long term disability insurance or a medical insurance plan from work?

☐ Yes ☐ No (if yes, fill in below)

Type of Coverage: ______________________________

Insurer: ______________________________

Policy Number: ______________________________

Where you injured during the course of your employment?

☐ Yes ☐ No (if yes fill in below)

If so, have you submitted a claim to the WSIB?

☐ Yes ☐ No

Claim Number: ______________________________

Previous Accidents or Injuries

Have you ever been in a previous motor vehicle accident or other type of accident, such as a slip and fall?

☐Yes ☐ No

If you answer yes, provide details (date of the accident and the nature of your injuries):

Pre-Existing Medical Conditions

Do you have any pre-existing medical conditions, including physical and/or psychological injuries or impairments?

☐Yes ☐ No

Do you have any pre-existing conditions, impairments or injuries that may be a barrier to your recovering from the injuries sustained in the accident?

☐Yes ☐ No

Please provide details (use back of page if necessary):

Accident Information

How many cars were involved in the accident? __________

Were you the driver or a passenger of the vehicle, or a pedestrian (circle one).

Where were you sitting in the car? ______________________________

Were you at fault? ☐ Yes ☐ No

Were any charges laid? ☐ Yes ☐ No

Against Whom?_ ____

Do you have any information relating to the above charges? ☐ Yes ☐ No ☐ N/A

Were you wearing your seatbelt? ☐ Yes ☐ No

Did you report the accident to a collision center? ☐ Yes ☐ No

Did the police or other emergency vehicles attend the scene? ☐ Yes ☐ No

☐ Police ☐ Ambulance ☐ Fire

Were you hospitalized? ☐ Yes ☐ No

Which Hospital? ____

Who treated you? ____

For How Long? ____

Medication Prescribed: ____

Did you receive any x-rays or other procedures? ☐ Yes ☐ No

Please provide details below (use the back page if necessary) :

What Injuries Did you Suffer? (Check all that apply)

☐ HEAD ☐ NECK ☐ SHOULDERS ☐ ARMS

☐ ELBOW ☐ HANDS ☐ U. BACK ☐ M. BACK

☐ L. BACK ☐ HIPS ☐ THIGHS ☐ KNEE

☐ LEGS ☐ ANKLES ☐ FEET ☐ CHEST

☐ ABS ☐ RIBS ☐ HEADACHE ☐ DIZZINESS

☐ NAUSEA ☐ JAWS (TMJ) ☐ DIFFICULTY SLEEPING

☐ DEPRESSION ☐ IRRITABILITY

Vehicle Information

(Please provide copies of insurance policies and ownership, if you have them with you)

Vehicle 1 (The vehicle you were in or the vehicle that hit you)

Make: __________ Model: __________ Year: _____ Lic. Plate # __________

Driver's Name: ______________________________
Address: ______________________________
____
____

Phone #: _______________

Auto Insurance Company: ______________________________

Policy Number: ______________________________

Owner's Name: ______________________________
(*if different from the driver)*
Address: ______________________________
____
____

Phone #: _______________

Auto Insurance Company: ______________________________

Policy Number: ______________________________

Vehicle 2 (The other vehicle)

Make: __________ Model: __________ Year: _____ Lic. Plate # __________

Driver's Name: ______________________________

Address: ______________________________
____
____

Phone #: _______________

Auto Insurance Company: ______________________________

Policy Number: ______________________________

Owner's Name: ______________________________
(*if different from the driver)*

Address: ______________________________
____
____

Phone #: _______________

Auto Insurance Company: ______________________________

Policy Number: ______________________________

FOR OFFICE USE

DETAILS OF THE ACCIDENT:

Medical Team Contact Information

Family Doctor: ________________________________
Address: ________________________________
____
____

Phone Number: ________________ Fax Number _____________________

When was the last time you saw your family doctor? __________________________

Other Medical Professionals You Have Seen

(i.e. other doctors, chiropractors, physiotherapists, etc.)

Name and Type of Professional: ________________________________
Address: ________________________________
____
____

Phone Number: ________________ Fax Number _____________________

Name and Type of Professional: ________________________________
Address: ________________________________
____
____

Phone Number: ________________ Fax Number _____________________

Name and Type of Professional: ________________________________
Address: ________________________________
____
____

Phone Number: ________________ Fax Number _____________________

Name and Type of Professional: ________________________________
Address: ________________________________
____
____

Phone Number: ________________ Fax Number _____________________

(*If you have seen more professionals, please provide further details:* ___________

Employment and Education Information

What is the highest level of education you have completed?: _______________

Status at the time of the accident:
☐ Employed ☐ In School ☐ Unemployed ☐ Homemaker

Current Employer (or School) ____

Your Position (or Program) ____

Commenced working/studying: (dd/mm/yy) _______________
Address: _________________________ Phone #: _______________
_________________________ Fax #: _______________
____

Supervisor's Name _________________________(*if applicable)*

Annual Salary/Cost of Tuition: ____________________ ***or*** (*if applicable*)
Hourly Wage: __________ **and** Hours/week: __________

Have you returned to work/school since the accident: ☐Yes ☐ No
Duties and Responsibilities:

Previous Employer ____

Duration of Employment ____

Address: _________________________ Phone #: _______________
_________________________ Fax #: _______________
____

Supervisor's Name _________________________

Annual Salary: ____________________ ***or*** (*if applicable*)
Hourly Wage: __________ **and** Hours/week: __________

Duties and Responsibilities:

Previous Employer ____

Duration of Employment ____

Address: _________________________ Phone #: _______________
_________________________ Fax #: _______________
____

Supervisor's Name _________________________

Annual Salary: ____________________ ***or*** (*if applicable*)
Hourly Wage: __________ **and** Hours/week: __________

Duties and Responsibilities:

Previous Employer ____

Duration of Employment ____

Address: _________________________ Phone #: _______________
_________________________ Fax #: _______________
____

Supervisor's Name _________________________

Annual Salary: ____________________ ***or*** (*if applicable*)
Hourly Wage: __________ **and** Hours/week: __________

Duties and Responsibilities: