AUTO ACCIDENT QUESTIONNAIRE

1. What was the date of the accident? _____
2. About what time did the accident occur? _____
3. How many vehicles were involved in the accident? _____
4. What was the estimated damage to the vehicle you were in? _____
5. What road were you traveling on? _____
6. What direction were you traveling in? _____
7. What city did the accident occur in? _____
8. What state did the accident occur in? _____
9. What type of impact was the auto accident? _____
10. Did your vehicle hit anything after the accident? If yes, please describe.

    _____

11. Where were you sitting in the vehicle during the accident?

    _____

12. Did you know the accident was coming? _____ 12b. Did you brace yourself? _____
13. What type of vehicle were you in? _____
14. What type of vehicle impacted yours? _____
15. At the time of impact, was your vehicle:
    - ☐ Slowing down
    - ☐ Stopped
    - ☐ Gaining speed
    - ☐ Moving at a steady speed

15b. About how fast was your vehicle moving? _____

16. At the time of impact, was the other vehicle:
    - ☐ Slowing down
    - ☐ Stopped
    - ☐ Gaining speed
    - ☐ Moving at a steady speed

16b. About how fast was the other vehicle moving? _____

17. During and after the crash what happened to your vehicle? (Circle all that apply)
    - ☐ kept going straight
    - ☐ kept going straight hitting a car in front
    - ☐ was hit by another vehicle
    - ☐ spun around
    - ☐ spun around and hit a stationary object
    - ☐ hit a stationary object

18. Did you lose consciousness during the accident? _____
19. How was your head positioned during the accident? _____
20. How was your torso positioned during the accident? _____
21. How were you hands positioned during the accident? _____

22. Did your head hit anything during the accident? ☐ No ☐ Yes, please describe _____
23. Did your face hit anything during the accident? ☐ No ☐ Yes, please describe _____
24. Did your shoulders hit anything during the accident? ☐ No ☐ Yes, please describe _____
25. Did your neck hit anything during the accident? ☐ No ☐ Yes, please describe _____
26. Did your chest hit anything during the accident? ☐ No ☐ Yes, please describe _____
27. Did your hips hit anything during the accident? ☐ No ☐ Yes, please describe _____
28. Did your knees hit anything during the accident? ☐ No ☐ Yes, please describe _____
29. Did your feet hit anything during the accident? ☐ No ☐ Yes, please describe _____
30. What kind of headrest was in your vehicle?
    - ☐ Movable fixed headrest
    - ☐ Non-movable fixed headrest
    - ☐ No headrest
31. Where was the headrest positioned on your head? _____
32. Did you have your seatbelt on during the accident? ☐ Yes ☐ No
33. Did you slide out of your seatbelt during the accident? ☐ Yes ☐ No
34. What was damaged in your vehicle? (Check all that apply)

☐ windshield	☐ rear bumper	☐ mirror
☐ steering wheel	☐ front bumper	☐ knee bolster
☐ dashboard	☐ trunk	☐ back right door
☐ seat frame	☐ front left door	☐ completely totaled
☐ side window	☐ front right door	
☐ rear window	☐ back left door	

35. Check the items that dented inward.
    ☐ floorboards ☐ side door ☐ dashboard
36. Check the doors that would not open as a result of the accident.
    ☐ front left ☐ front right
    ☐ rear left ☐ rear right
37. Did you go to the hospital? If not, why? (Skip Questions 38-43)

    _____
38. How did you get to the hospital? _____
39. What was the name of the hospital? _____
40. Were you hospitalized overnight? ☐ Yes ☐ No
41. Check what you were prescribed at the hospital.
    ☐ pain medication ☐ muscle relaxants ☐ neck brace
42. Did you receive any stitches for any cuts at the hospital? _____
43. Were any x-rays/MRI/other tests taken at the hospital? If yes, which area was taken?

    _____

AUTO INSURANCE INFORMATION

Have you filed a claim with your auto insurance company? ☐ No ☐ Yes

YOUR Auto Insurance Company: _____

Address: _____

Phone #: _____

Claim #: _____ Adjuster's Name: _____

ATTORNEY INFORMATION

Have you retained an attorney? ☐ No ☐ Yes

Attorney Name: _____

Address: _____

Phone #: _____

Name: _____

Signature: _____

Address: _____

Phone: _____ home _____ cell

LIEN FORM

I do hereby authorize Dr. Steven Saro to furnish you, my attorney, with a full report of his examination, diagnosis, treatment, prognosis, etc., of myself in regard to the accident in which I was recently involved.

I hereby authorize and direct you, my attorney, to pay directly to said doctor such sums as may be due and owing him for medical services rendered to me both by reason of this accident and by reason of any other bills that are due to his office and to withhold such sums from any settlement, judgement or verdict as may be necessary to adequately protect said doctor. And I hereby further give a lien on my case to said doctor against any and all proceeds of my settlement, judgement or verdict which may be paid to you, my attorney, or myself, as a result of the injuries for which I have been treated or injuries in connection therewith.

I agree never to rescind this document and that a rescission will not be honored by my attorney. I hereby instruct that in the event another attorney is substituted in this matter, the new attorney honor this lien as inherent to the settlement and enforceable upon the case as if it were executed by him.

I fully understand that I am directly and fully responsible to said doctor for all medical bills submitted by him for service rendered to me and that this agreement is made solely for said doctor's additional protection and in consideration of his awaiting payment. And I further understand that such payment is not contingent on any settlement, judgement or verdict by which I may eventually recover said fee.

Please acknowledge this letter by signing below and returning to the doctor's office. I have been advised that if my attorney does not wish to cooperate in protecting the doctor's interest, the doctor will not await payment but will require me to make payments on a current basis.

PATIENT'S SIGNATURE:_____ DATED: _____

HEALTH INSURANCE AFFIDAVIT

Your claim for Personal Injury Protection benefits may be coordinated with your own personal Health Insurance per MGL c.90, Section 34M. In order to properly determine what benefits are payable, it is necessary for you to provide us with the information requested below. Thank you very much.

1. Are you eligible for coverage under any Health Insurance Plan? ☐ Yes ☐ No

   A. If Yes, please answer or **provide a copy of your health card, both sides**.

      Name of Plan: _____

      Address for claims: _____

      Telephone #: _____

      Group Plan #: _____

      Policy #: _____

      Subscriber Name: _____

      Social Security #: _____

   B. If No,

      Are you eligible for health coverage under any **government program**?

      ☐ Yes ☐ No

   C. If you are eligible under someone else's plan, please complete section A as well as the following:

      Member name: _____

      Relationship to you: _____

      Address of Member: _____

      Member Phone #: _____

      Member Date of Birth: _____

Applicant's Signature: _____ Date: _____