Automobile And Job Injury Information

Name _____ Date _____ Telephone _____

Address _____ City _____ State _____ Zip _____

JOB INJURY INFORMATION: Date _____ Time _____ Injury reported to employer _____

Employer _____ Employer's Address _____

Description of accident _____

_____

AUTO ACCIDENT INFORMATION: Date _____ Time _____ Police report made _____

Location _____

Were you struck from: Behind ☐ Right Side ☐ Left Side ☐ Front ☐ Were you: Driver ☐ Passenger ☐

Description of Accident: _____

_____

_____

_____

Were you injured _____ How _____

Where _____

Were you unconscious _____ Fractures _____ Cuts _____ Abrasions _____ Bruises _____

Patient taken to _____ Hospital for _____ treatment.

Confined to hospital for _____ Days Hours. Name of hospital doctor _____

What are your present complaints: _____

_____

_____

What treatments have you received _____

OTHER DOCTORS SEEN FOR THIS CONDITION: MD ☐ DC ☐ DO ☐ DDS ☐

Doctor's name _____ Diagnosis _____

X-rays _____ Urinalysis _____ Blood Tests _____ Other _____

Treatment: Pills _____ Shots _____ Traction _____ Physiotherapy _____

Results _____ Length of time under his care _____ Other _____

Have you had any problems as the result of the injury _____

_____

Were you off work _____ If so, how long _____

Have you returned to your same job _____ If not, why _____

HISTORY OF PRIOR INJURY, ILLNESS OR SURGERY: _____

_____

_____

Name of other party _____ Address _____

City _____ State _____ Phone _____

Their insurance company _____ Insurance Agent _____

ATTORNEY: Name _____ Address _____ Phone _____

Litigation: Yes ☐ No ☐ Maybe ☐

INSURANCE INFORMATION:

Do you have any group, union or personal health and accident insurance? Yes ☐ No ☐

Name of Insurance Company _____ Claim No. _____

Address _____ Agent _____

Patient's Signature: _____

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MISSION SPECIALTIES CO. - BOX 185 - SAN LEANDRO, CA 94577