ACCIDENT REPORT

Last Name:	First:	Middle:	Today's Date:

Your Auto Insurance Company Name:	Your Auto Insurance Mailing Address, City, State, Zip	Your Auto Insurance Phone Number

Insured's Name:	Policy Number:	Accident Claim #:

Has the accident been reported to your insurance? ❑ **Yes** ❑ **No**

Liable Party's Insurance Company:	Liable Party's Auto Insurance Mailing Address, City, State, Zip	Liable Party's Insurance Phone Number

Have you signed up with an attorney for this accident? ❑ Yes ❑ No	If not, when is appointment?

Attorney Name:	Address City, State, Zip	Phone

Date of Accident:	Place of Accident:

Description of Accident:

What symptoms and/or pain have you had since the accident:

Patient/Parent/Guardian Signature: **Date:**

Witness: **Date:**