Advanced Neuropathy Clinic

469-814-9787

Motor Vehicle Accident/Work Related Injury Questionnaire

Was your medical treatment the result of an injury? Yes ( ) No ( )
If you answered no, please explain reason for medical treatment:

_____

_____

Please Answer Below:
A. Date of accident or injury: _____
B. Did injury occur as a result of an automobile accident? Yes ( ) No ( )
C. Did injury happen while working? Yes ( ) No ( )
D. Did injury occur on another person's property? Yes ( ) No ( )
E. Were any family/household members in the accident? Yes ( ) No ( )
F. Name of family/household members in accident: _____
3. Please provide a brief description of accident and provide copy of any accident reports, if possible (police report, insurance claim form, etc.):

_____

_____

Please provide the following accident information:
A: Location of accident: _____
(Street) (City) (State) (Zip)
B. Name, address, and phone number f other person(s) or property owner involved in accident:

_____

_____

C. Name, address, and phone number of other person(s) or property owner's insurance company:

_____

_____

D. Your auto insurance company's name, address, phone number, and policy number, or family/household members insurance company's name, address, phone number, and policy number:

_____

_____

Have you hired an attorney or/and have an adjuster because of your injuries from the accident/incident? Yes ( ) No ( )
If you answered yes, please list your attorney's/ adjuster's name, address, and phone & fax number:

_____

_____

Have you received any settlement or insurance money due to this accident or injury? Yes ( ) No ( )
If you answered yes, please list who paid you and the amount you were paid:

_____

_____

THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE

_____ _____

Signature Date