Absolute Health
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AUTO ACCIDENT INFORMATION

Name:_____ Date of Accident: _____/_____/_____

Make/Model of vehicle you were in:_____
Position in vehicle:_____
Amount of damage to vehicle:_____
Action of your vehicle at the time of collision?_____
In what state did the collision occur? _____
Weather Conditions:_____Road Conditions:_____
Time of Day:_____Visibility:_____
Describe the collision:_____
_____
_____
Did you lose consciousness? Y N
Seatbelt? No Lap Only Shoulder Only Shoulder/Lap Belt
Did the airbags deploy? Y N Position of headrests? Up Down
Did you anticipate the collision / brace for impact? Y N
Were you taken to the ER? Y N
What did they do at the ER?_____

Make/Model of the other vehicle:_____
Amount of damage to other vehicle?_____

Policy Holder of the car you were in during the accident:_____
Relationship to Policyholder:_____
Insurance Company:_____
Address:_____
Phone #_____ Claim Adjuster:_____
Policy or Claim #_____ Reported to Insurance Co? Y N
Was there a Police Report? Y N

Have you contacted an Attorney? Y N
Attorney's name?_____
Address:_____
Phone #:_____

Have you been involved in any prior motor vehicle collision? Y N
If yes, please describe:_____
_____