WEST END CHIROPRACTIC & REHABILITATION
4255 Laclede Ave.
St. Louis, MO 63108
Telephone: (314) 361-4650
Fax: (314) 361-4663

# INSURANCE INFORMATION FOR MOTOR VEHICLE ACCIDENTS

Note: The information given is not your name and address or the person who hit you, but the auto insurance companies involved and their addresses and the adjusters and claim numbers assigned to your accident. **YOU CAN TAKE THIS HOME WITH YOU, BUT YOU MUST RETURN IT BY YOUR SECOND VISIT – OR WE WILL BE UNABLE TO SEE YOU UNTIL YOU HAVE ALL THIS INFORMATION TO OUR OFFICE**

***YOUR CAR INSURANCE INFORMATION****: (or the person whom you were riding with)*

***MEDICAL PAY****: (You may or may not have this, if yes, we need the declaration page of your policy)*

Insurance Company: ______________________________

Address: ______________________________

City/State/Zip: ______________________________

Phone: ______________________________

Claim Number: ______________________________

Adjusters Name: ______________________________

***INSURANCE COMPANY OF THE PERSON WHO HIT YOU***

Insurance Company: ______________________________

Address: ______________________________

City/State/Zip: ______________________________

Phone: ______________________________

Claim Number: ______________________________

Adjusters Name: ______________________________

***YOUR HEALTH INSURANCE***

Insurance Company: ______________________________

Address: ______________________________

City/State/Zip: ______________________________

Phone: ______________________________

Policy Number: ______________________________

Adjusters Name: ______________________________

***ATTORNEY*** (If you have retained an attorney due to this accident or if you get one at a later date, let us know)

Name: ______________________________

Address: ______________________________

City/State/Zip: ______________________________

Phone: ______________________________

**KNOW THE LAW:** IN MISSOURI, YOU ARE ENTITLED TO BILL ALL INSURANCE COMPAINES THAT APPLY. MISSOURI INSURANCE REGULATION 4 CSR 190-17.100(3) STATES THE FOLLOWING: "***In no event shall an insurer request an increase in premium from any insured in connection with any claim arising out of any accident for which the insured was not at fault. In connection with any accident caused by the insured, an insurer may request an increase in premium as a result of payment by an insurer to or on behalf of the insured in settlement of any claim made by or against the insured."***

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# VEHICLE ACCIDENT REPORT

Name: ________________________________________________________________________________________________

Date of Accident ____/____/_____ Time of Accident ___________ am/pm

Were you: Driver Passenger (Front) Passenger (Rear L or R) Pedestrian

Were you wearing seatbelt(s)? Yes/No Type of Vehicle: Auto Truck Van M/C Other:_______

Year/Make/Model of your vehicle: ________/________/________ Estimated damage amount: $ __________________

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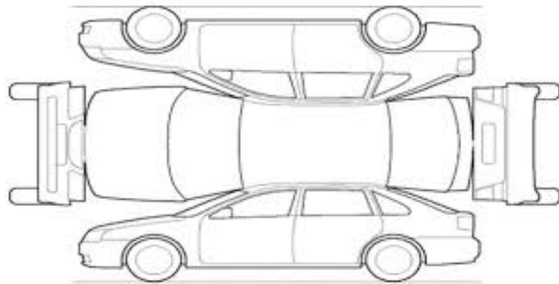
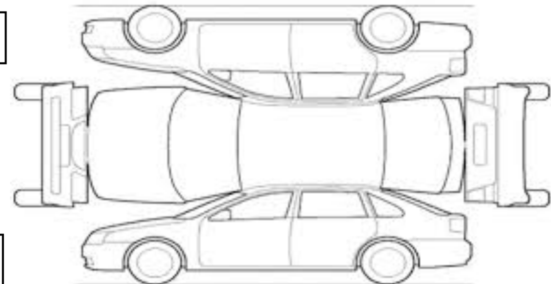
How accident occurred: Struck by another vehicle Struck another vehicle Struck a stationary object Other _______________

Where was **your** vehicle hit? Where was **their** vehicle hit?



Right Side

Left Side



Your approximate speed _____MPH Their approximate speed _____MPH

Did the airbag deploy? Yes/No What occurred at the moment of impact? (Circle as many as apply):

Tensed body for impact / Neck whipped forward & back / Spine torqued and twisted / Thrown over seat / Thrown from vehicle / Pinned in vehicle / Thrown from side to side / Cut and bruised

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Did you strike your: (Please write corresponding letters next to the body regions injured.)

| BODY REGION | | | | OBJECT YOU HAD CONTACT WITH | EXAMPLE: |
|---|---|---|---|---|---|
| Head | _______ | _______ | _______ | A. Windshield | Head *A. J.* |
| Face | _______ | _______ | _______ | B. Side Window | Knee *D. C.* |
| Shoulder | _______ | _______ | _______ | C. Side Door | |
| Arm/Hand | _______ | _______ | _______ | D. Dashboard | |
| Front chest wall | _______ | _______ | _______ | E. Knee bolster/Glove compartment | |
| Ribs | _______ | _______ | _______ | F. Seatbelt | |
| Hip/Abdomen | _______ | _______ | _______ | G. Frame of car near windows | |
| Knee | _______ | _______ | _______ | H. Roof of window | |
| Leg | _______ | _______ | _______ | I. Another occupant/Animal | |
| Foot | _______ | _______ | _______ | J. Roof / Steering wheel / Column | |

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Were you rendered unconscious? Yes/No Were you treated by EMS/paramedic at scene? Yes/No

Did you go to the hospital? Yes/No If "YES", when? Immediately / _____ hours later / _____ days later

Which hospital? ______________________ Did you get x-rays? Yes/No If "YES", what body regions _____________________________

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Did you have any physical complaints before the accident? Yes/No If "YES" please describe: ____________________________________________

______________________________________________________________________________________________

______________________________________________________________________________________________

In your own words, please describe accident: ____________________________________________________________________

______________________________________________________________________________________________

______________________________________________________________________________________________

______________________________________________________________________________________________

______________________________________________________________________________________________

______________________________________________________________________________________________

How did you feel immediately after the accident? ________________________________________________________________

______________________________________________________________________________________________

______________________________________________________________________________________________

______________________________________________________________________________________________

SPACE LEFT INTENTIONAL BLANK

**IMPORTANT**: This form may be used in the determination of insurance benefits and/or litigation for compensations. It is imperative that this form be filled out completely to protect your rights of compensation.