



MyHealth Care Centre
 317 Queen St South
 Streetsville, ON
 905.593.5000

Look Better.
 Feel Better.
 Live Better.

MOTOR VEHICLE ACCIDENT

NAME: _____

DATE: _____

In order to better serve you, we will need some basic information about your accident.

Please give us the make, model and year of your vehicle: _____

Describe What Happened: _____

- | | |
|--|---------------------------------|
| 1. Where in the car were you at the time of the accident? | Driver/Passenger/Backseat/Other |
| 2. Were you wearing a seatbelt at the time of the accident? | Yes/No |
| 3. What were the road conditions like at the time of the accident? | Icy/Wet/Dry/Snowy/Other |
| 4. Did the airbag deploy? | Yes/No |
| 5. Did you hit your head? | Yes/No If so where _____ |
| 6. Did you lose consciousness (blackout)? | Yes/No If so how long _____ |
| 7. Did you have any symptoms experienced immediately? | Yes/No Explain _____ |
| 8. After the accident were you taken to the hospital? | Yes/No Explain _____ |
| 9. Did you have any x-rays taken after the accident? | Yes/No |
| 10. Did you see your family doctor after the accident? | Yes/No If so when _____ |
| 11. Did you receive any treatment (including prescriptions)? | Yes/No Explain _____ |
| 12. Were you previously taking any medications for other conditions? | Yes/No |
| 13. Have you ever been involved in a previous car accident? | Yes/No If so when _____ |
| 14. Did you previously have any injuries or conditions? | Yes/No Explain _____ |
| 15. Have you been contacted by an insurance adjuster regarding this claim? | Yes/No |
| 16. Do you have an attorney that has advised you in this case? | Yes/No |

Office Information:

Insurance company	
Contact Name/Number	
Policy number	
Claim number	
Accident date/time	