



## Auto Accident Questionnaire

1) What was the date of your accident? \_\_\_\_\_

2) Do you have auto insurance? Yes \_\_\_\_\_ No \_\_\_\_\_

**\*If you checked "yes," please provide a copy of your auto insurance card.**

3) Have you reported the accident to your insurance company? Yes \_\_\_\_\_ No \_\_\_\_\_

4) Have you completed an application for benefits form\*? Yes \_\_\_\_\_ No \_\_\_\_\_

\*Your insurance company will send you this form, and it must be completed in order for you to be eligible for the medical coverage you are entitled to through your auto insurance policy. If you need help completing it, please feel free to bring it in and someone from HHWC will be happy to walk you through it.

5) Have you seen any other type of health care provider for treatment relating to your auto injuries?

Yes \_\_\_\_\_ No \_\_\_\_\_

If so, please list all other health care providers and types of treatment you have received for care relating to the accident:

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6) Have you contacted a lawyer regarding your accident? Yes \_\_\_\_\_ No \_\_\_\_\_

Lawyer: \_\_\_\_\_ Phone: \_\_\_\_\_

7) Please give us a brief description of the accident:

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