Please print this form from your computer, complete all applicable sections on both pages neatly and bring it to the office with you for your first visit.

Central Jersey Orthopaedic Specialists, P.A.

Auto Accident Form

PATIENT NAME:_____DATE OF EXAMINATION:_____.
(LAST NAME, FIRST NAME)

The following information is needed to help the doctor learn how you were injured, what treatment you've had, and Other information needed for insurance claims. It will shorten examination time. Please answer the questions as best you can. If a question is not clear, do not guess; just place a question mark next to it and the doctor will ask what is needed. Read all choices before answering. Please do not squeeze writing; if you need more room, place an arrow at the end of the line and continue on the other side. Thank you.

DATE OF ACCIDENT_____**WHERE** IT OCCURRED (CITY,STATE) _____.
(If you have been injured in more than one accident, please complete a separate form for each one.)

TYPE OF VECHICLE YOU WERE IN/ON (*If any – check one):*
□ *AUTO* □ *VAN* □ *PICK-UP TRUCK/SUV* □ *BUS* □ *BICYCLE* □ *MOTORCYCLE*
□ *MOPED OR ATV* □ *NONE-WAS PEDESTRIAN STRUCK BY VECHICLE*
□OTHER _____

VECHICLE I WAS IN/ON WAS STRUCK (Check all that apply):
□ *IN REAR* □ *HEAD ON* □ *ON DRIVER'S (LEFT)SIDE* □ *ON PASSENGER (RIGHT)SIDE*
□ *NEAR FRONT FENDER* □ *MID SECTION* □ *NEAR REAR FENDER*
□OTHER _____

NATURE OF COLLISION (Check all that apply):
□ *COLLIDED WITH ONE OR MORE VECHICLES* □ *VECHICLE LOST CONTROL*
□ *STRUCK DIVIDER/GUARDRAIL* □ *STRUCK POLE/TREE* □ *ROLLED OVER* □ *SPUN ABOUT* □ *WENT INTO DITCH*
□OTHER _____

YOUR POSITION IN/ON VECHICLE (Check which one):
□ *DRIVER* □ *FRONT SEAT PASSENGER* □ *BACK-SEAT PASSENGER* □ *PEDESTRIAN*
□OTHER _____

SEATBELTS (Check which one):□ *WORE COMBINATION LAP/CHEST RESTRAINT* □ *WORE CHEST RESTRAINT ONLY*
□ *WORE LAP RESTRAINT ONLY* □ *VECHICLE HAD NONE* □ *AVAILABLE NOT FASTENED*

AIRBAG DEPLOYED: □ *YES* □ *NO* □ *VECHICLE HAD NONE*

DATE OF FIRST VISIT TO DOCTOR/HOSPITAL/EMERGENCY ROOM,ETC. (MONTH/DAY/YEAR) _____/_____/_____.

NAME OF HOSPITAL(S) OR EMERGENCY FACILITY(IES) YOU WENT TO _____

NAMES OF DOCTORS WHO TREATED YOU FOR THIS ACCIDENT_____

WHERE HAVE YOU HAD X-RAYS, SCANS, ETC? _____

YOUR JOB AT TIME OF ACCIDENT:_____□ FULL TIME □ PART TIME

HOW LONG UNABLE TO WORK IMMEDIATELY AFTER ACCIDENT: ._____

YOUR CURRENT JOB:_____□ FULL TIME □ PART TIME

EVER INJURED IN OTHER AUTO ACCIDENT(S)? □ YES □ NO IF YES, WHEN? _____

EVER INJURED IN OTHER KINDS OF ACCIDENT(S)? □ YES □ NO IF YES, WHEN_____
(e.g. slips and falls, work accidents)

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Assignment of Personal Injury Protection Benefits and Collection Rights

I, _____ residing at _____

_____ , being of full age/, hereby assign as follows:

1. On or about _____ I / my dependent, was involved in an automobile accident in _____, New Jersey and sustained personal injuries.
2. At the time of my accident, I was eligible for Personal Injury Protection benefits under the following insurance carrier-_____

   Policy Number:_____
3. As a result of the injuries sustained in this accident, I sought and obtained medical treatment from Central Jersey Orthopaedic Specialists.
4. In consideration of the services rendered or to be rendered to me by Central Jersey Orthopaedic Specialists; I hereby authorize _____ Insurance Company to pay any and all PIP medical benefits to which I may be entitled directly to Central Jersey Orthopaedic Specialists.
5. In addition, I hereby assign directly to Central Jersey Orthopaedic Specialists any and all PIP collection rights to which I may be entitled.
6. I have not been coerced in any way to give this assignment.

You must initial one of the sentences below

_____ I have notified my motor vehicle insurance carrier of the accident and filed the necessary PIP Application. I will furnish Central Jersey Orthopaedic Specialists with a copy of the PIP Application.

__ I have not notified my motor vehicle insurance carrier of the accident and agree to *personally* reimburse CENTRAL JERSEY ORTHOPAEDIC SPECIALISTS for all services rendered.

I have read the above statements and believe it to be true to the best of my knowledge.

_____ _____
Patient Signature/Responsible Party Date

_____ _____
Witness Date