hines HEALTH 305 N. 24th Street Rogers, AR 72756-3294 (479) 636-3021

MOTOR VEHICLE COLLISION (MVC) REPORT

It is the policy of Hines Health Clinic to file charges with your automobile insurance. Your Insurance will file against the responsible party for reimbursement. Otherwise you are responsible for payment at time of service. Police report is required.

Your name _____ date_____
Date of Accident _____ Time of accident _____ City/State _____
Road Conditions at time of accident ◯wet ◯dry ◯ icy ◯other
Did Police come to the scene? ◯yes ◯no
Have you requested Police Report? ◯ yes ◯no

Medical Care You Recieved

Did you go to the hospital? ◯no ◯yes which one_____
How did you get to the hospital? ◯ self ◯ambulance ◯friend ◯ other
What parts of your body were X-Rayed at the hospital? _____
What did the hospital do for your injuries?_____
How long did you stay at the hospital?_____

Injuries you Sustained

What bleeding cuts did you sustain during the accident?_____
What bruises did you sustain during the accident? _____
Where were you seated in the vehicle? ◯driver ◯ front passenger ◯ back seat
Were you aware of the approaching collision prior to impact? ◯aware ◯surprised
Did you lose consciousness (black out) upon impact? ◯no ◯ yes ◯ ____how long
Did you experience a flash of light or explosion in your head? ◯yes ◯no
Did you experience any of these following your accident:

☐ confused	☐ disoriented	☐ lightheaded	☐ dizzy
☐ nauseated	☐ blurred visions	☐ ringing/buzzing in ears	

If you still have any of these symptoms above, which ones? _____
Are you currently suffering from any of the following:

☐ difficulty concentrating	☐ restlessness	☐ sleeplessness
☐ reduced tolerance to heat	☐ difficulty with memory	☐ chills
☐ reduced tolerance to cold	☐ irritable	☐ forgetfulness

Your Position in the Car

How far is the top of the headrest or seat back from the top of your head_____inch
Were you wearing your seat belt? ◯ yes ◯ no Is it ◯ lap belt or ◯ shoulder lap
List the year, make, and model of the vehicle you were in:
Year _____ Make _____ Model _____
Was your car stopped at the time of impact ◯ yes ◯ no
If yes, was the driver's foot also on the brake ◯ yes ◯ no
If your vehicle was moving, estimate the speed you were traveling _____mph
If your vehicle was moving, was it ◯ slowing down ◯ speeding up ◯ steady rate

Damage inside your car

What areas of your body were struck inside the automobile?

- ☐ Head Hit
- ☐ Right/Left Shoulder
- ☐ Right/Left Hip
- ☐ Right/Left Knee
- ☐ Chest Hit
- ☐ Right/Left Arm
- ☐ Right/Left Leg
- ☐ Other _____

Did you receive a bruise or injury from seat belt? ◯ yes ◯ no
Was the trunk of your body pointed straight forward at the time of collision ◯ yes ◯ no
If no, which direction were you turned? _____
Was your head pointed straight forward? ◯ yes ◯ no ◯ other

What is the estimated cost damage to the vehicle you were in? _____
Which of the following car parts broke during the accident:

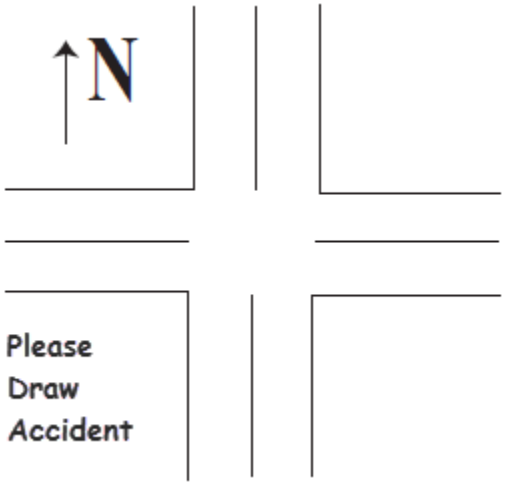
- ☐ Windshield
- ☐ Steering Wheel
- ☐ Knee bolster
- ☐ Side Window
- ☐ Front seat back
- ☐ Rear bumper
- ☐ Dashboard
- ☐ Rear Window
- ☐ R/L side window
- ☐ Front bumper
- ☐ Trunk
- ☐ Totaled

The Other Vehicle

What is the year, make and model of the other vehicle?
Year _____ Make _____ Model _____
Was the other vehicle moving at the time of the collision, was it?
◯ Slowing down ◯ Gaining speed ◯ Steady speed
How many vehicles were involved in the accident? _____
What direction were your traveling in? ◯ North ◯ South ◯ East ◯ West
What type of impact was the auto accident?_____

During and after the crash what happened to your vehicle?

- ◯ Kept going straight
- ◯ Spun around & hit another car
- ◯ Ran into the car in front
- ◯ Spun around & hit something else



Please describe, to the best of your knowledge, what happened during this accident:

_____
_____
_____
_____
_____
_____
_____
_____

Automobile Insurance Information

Insured's Name_____

Medical Payment Coverage (Personal Injury Protection) ◯ Yes ◯ No
If not covered by your insurance, we will submit charges to the other party's auto insurance however you will be responsible for payment of charges at the time of service.

Insurance Company
Name_____
Address_____
_____
Claim No._____
Policy No._____
Adjuster / Team_____
Telephone No._____
Fax No._____

Other Party's Name
_____
Insured's Name_____
Insurance Name_____
Address_____
_____
Claim No._____
Policy No._____
Adjuster / Team_____
Telephone No._____
Fax No._____