

ACCIDENT QUESTIONNAIRE

PLEASE ANSWER ALL QUESTIONS COMPLETELY

DATE OF ACCIDENT _____ TIME OF ACCIDENT _____ AM PM

TYPE OF ACCIDENT: AUTO _____ WORKERS' COMP _____ SLIP & FALL _____ OTHER _____

IF WORKERS INJURY: DID YOU REPORT ACCIDENT TO EMPLOYER? _____

DID YOU FILL OUT ACCIDENT REPORT? _____

IF AUTO INJURY: WERE POLICE CALLED? _____ DID YOU GET POLICE REPORT? _____

PLEASE EXPLAIN THE DETAILS OF HOW YOUR ACCIDENT/INJURY OCCURRED _____

WHERE DID YOU FEEL PAIN IMMEDIATELY AFTER THE ACCIDENT? _____

LIST THE EXTENT OF INJURIES AS YOU KNOW THEM _____

DID YOU REQUIRE POST ACCIDENT HOSPITALIZATION? YES _____ NO _____
WHERE _____

CIRCLE SYMPTOMS YOU HAVE NOTICE SINCE THE ACCIDENT:

- | | | |
|---------------------|----------------------|-------------------------|
| HEADACHE | DIZZINESS | DEPRESSION |
| NECK PAIN/STIFFNESS | LIGHT BOTHERS EYES | BUZZING/RINGING IN EARS |
| MID BACK PAIN/STIFF | HEAD SEEMS TOO HEAVY | LOSS OF MEMORY |
| LOW BACK PAIN/STIFF | PINS/NEEDLES IN ARMS | LOSS OF BALANCE |
| STOMACH UPSET | PINS/NEEDLES IN LEGS | LOSS OF SMELL |
| SLEEPING PROBLEMS | NUMBNESS IN FINGERS | LOSS OF TASTE |
| FATIGUE | NUMBNESS IN TOES | CONSTIPATION |
| FAINTING | SHORTNESS OF BREATH | DIARRHEA |
| NERVOUSNESS | TENSION | FEVER |
| COLD FEET | COLD HANDS | CHEST PAIN |

SYMPTOMS OTHER THAN ABOVE _____

WAS ANY OTHER DOCTOR CONSULTED AFTER YOUR ACCIDENT? YES ___ NO ___

DOCTOR'S NAME & PHONE # _____

WHAT TREATMENT WAS GIVEN & DIAGNOSIS _____

DRIVER OF VEHICLE IN WHICH YOU WERE INJURED _____

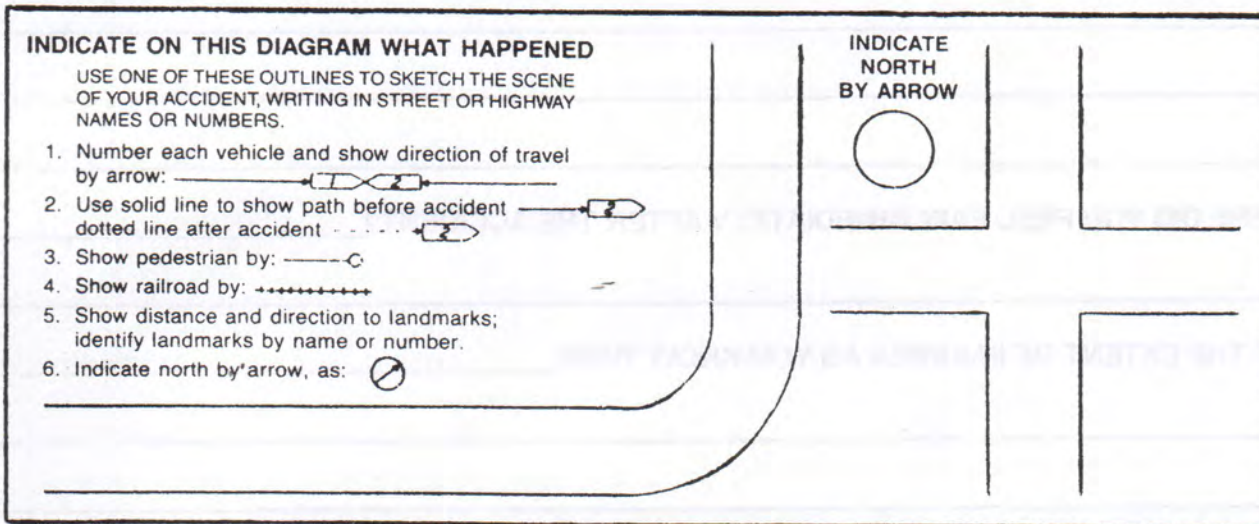
INSURANCE COMPANY OF DRIVER AND POLICY NUMBER _____

YOUR INSURANCE COMPANY AND POLICY NUMBER (IF DIFFERENT) _____

INSURANCE ADJUSTOR & PHONE _____ CLAIM # _____

HAVE YOU RETAINED AN ATTORNEY? YES ___ NO ___

ATTORNEY NAME _____ TELEPHONE #: _____



DOCTOR'S LIEN

I hereby authorize Dr. Alfred J. Santoro to furnish my attorney with a full report of his examination, diagnosis, treatment, prognosis, etc., of myself in regard to the accident in which I was involved.

I hereby authorize and direct my attorney to pay directly to Dr. Santoro such sums as may be due and owing him for professional services rendered me both by reason of this accident and by reason of any other bills that are due his office, and to withhold such sums from any settlement, judgement or verdict as may be necessary adequately to protect Dr. Santoro. I hereby further give a lien on my case to Dr. Santoro against any and all proceeds of any settlement, judgment, or verdict which may be paid to my attorney, or myself as the result of the injuries for which I have been treated or injuries in connection therewith.

I fully understand that I am directly and fully responsible to Dr. Santoro for all professional bills submitted by him for services rendered me, and that this agreement is made solely for Dr. Santoro's additional protection and in consideration of his awaiting payment. And I further understand that such payment is not contingent on any settlement, judgment, or verdict by which I may eventually recover said fee.

Dated: _____ Patient's Signature _____