Gleeson Clinic
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Motor Vehicle Accident Form

Personal Information

Last Name: ____________________________ First Name: ________________________ Initial: ______
Street Address: ____ Home Phone: (___)______________
City: _________________________________ Province: _____________ Postal Code: ______________
Birth Date: (D/M/Y) ________________________________ Male or Female (please circle your gender)
Health Card: __________________________________ Version Code: _________ Expiry: ___________
Employer's Name:___________________________ Occupation: ________________________________
Employer's Address: __________________________ Employer's Telephone: ______________________

Accident Information

Accident Date & Time (D/M/Y): ____
Did the accident occur in an employer's work vehicle or during work hours? Yes ( ) No ( )
If yes, please give details: ____

Automobile Insurance

Have you completed the OCF – 1 form and submitted it to your insurance company? ________________
Name of Auto Insurance Carrier: __________________ Name of policy member: ___________________
Policy No.: ______________________________ Your Claim or File No.: __________________________
Adjuster's Name: ___________________________ Adjuster's address: ____________________________
Telephone #: ___________________________________ Fax #: __________________________________

Extended Health Care Benefits

Do you have extended Health Care Benefits? ________ if yes, please provide the name of the Group Insurance Carrier: ______________________________ Name of policy member: __________________
Policy member's date of birth: ______________________ Identification No.:______________________
Policy No.: ___________________________ Details of Coverage (What services are covered? how much per year/per visit: ________________________________ Are 'Assignment of Benefits' allowed?________

Your position in the vehicle: (please circle) Driver Passenger Front Seat Back Seat
What type of vehicle were you in? _______________________ Number of persons in the vehicle: _____
Where did the accident occur? ____
Briefly describe the accident (in sequence) in your own words: ___________________________________
____
____
____
Exactly what area of your vehicle was struck? ____
Was another vehicle involved? _________ If yes, briefly describe the other vehicle: (Car, bus, transport truck etc.) ____
Upon impact, was your vehicle: (please circle) *stopped* *moving* *turning left or right*
Were you wearing a seatbelt? ___________ Was your vehicle equipped with headrests? _____________
Upon impact, which way were you thrown? ____
What did you strike? (please circle) *Steering wheel* *Dash* *Door* *Windshield* *Other:*
____

Were you able to get out of the vehicle and walk? __________ Were charges laid? _________________
Have you been involved in a previous motor vehicle accident? __________ If yes, please provide details:
____
____
When did your symptoms first appear? (please circle) Upon Impact Right After Hours Later Days Later Weeks Later Months Later Years Later
Location(s) of pain: ____
Describe the type of pain experienced and what movement(s) aggravate it, or is the pain constant?
____
Does pain radiate or shoot? ____
Upon onset of symptoms, could you move all body parts normally? _________ If no, please describe:
____
____
Did you or are you presently experiencing any of the following symptoms? (please circle) joint pain stiffness sleep difficulty nervousness depression loss of consciousness dizziness nausea vomiting blinding explosion feeling headaches unusual sensations in arms or legs bleeding back pain tingling numbness swelling other: (please describe)___________________________
____
Were you taken to the hospital? _________ If yes, which hospital? ______________________________
Were x-rays taken? _________ If yes, which area(s) of the body? _______________________________
____ Date taken: _______________________
Have you been off work with this injury? If YES, please list dates: ______________________________
____
____
Describe your current symptoms: ____
____
Are your symptoms improving or worsening? ____
Does anything relieve your current symptoms? ____
Does anything aggravate your current symptoms? _____________________________________
Have you been receiving any medical/health care for your symptoms? ________________________
Please describe care: ____
Doctor's Name: _______________________ Diagnosis: ___________________________________
How many visits? _____________ Have you received therapy? ____________________________
Type of therapy? ____________________________ Frequency of therapy: _____________________
Response to therapy: ____

The above information is essential to assess your injury. All questions must be answered as accurately as possible in order to process your claim.

I understand that by signing this form, I am responsible for all account balances not covered (regardless of the reason) by OHIP, my Extended Health Carrier and/or my Auto Insurance Carrier.

Patient Signature: __________________________________

Witness to Signature Above: __________________________ Date Signed: _________________