AUTO ACCIDENT

PATIENT NAME:____
ADDRESS: ____
____
PHONE # : ____
SS#: ____

WHICH INSURANCE IS PRIMARY FOR YOUR ACCIDENT:
_____AUTO INSURANCE _____HEALTH INSURANCE

INSURANCE CO. NAME: ______________________________________
ADDRESS: ____________________________________
____
PHONE # ____________________________________
ADJUSTER: ____________________________________
POLICY #: ____________________________________
CLAIM #: ____________________________________
D.O.I.: ____________________________________

ATTORNEY NAME: ____
ADDRESS: ____
____
PHONE #: ____

WERE YOU A ______DRIVER ______PASSENGER _____PEDESTRIAN

_______ I ELECT NOT TO GO THROUGH MY CAR INSURANCE. PLEASE BILL MY PERSONAL MEDICAL INSURANCE. I UNDERSTAND I AM FULLY RESPONSIBLE FOR THE PORTION OF MY BILL THAT MY MEDICAL INSURANCE DOES NOT PAY.

______________________________________ ______________________

PATIENT SIGNATURE DATE