AUTOMOBILE ACCIDENT INSURANCE INTAKE FORM

Patient Name:_____ Today's Date:_____

Date of Accident: _____

Do you have an Attorney? ( ) Yes ( ) No

If yes, Name:_____

Phone: _____

Please have your attorney contact us as soon as possible regarding your treatment with us.

MOTOR VEHICLE INFORMATION

Name of motor vehicle insurance we will be billing: _____

Name of ***your*** motor vehicle insurance: _____ (write SAME if same)

Contact/Adjusters Name: _____ Phone: _____

Claim Number: _____

Please list your personal health insurance company: _____

We reserve the right to collect a $20 fee for no shows and less than 24-hour notice cancellations; this cannot be billed to your insurance company.

I acknowledge the insurance information I have provided is true to the best of my knowledge.

Signature: _____ Date: _____