Personal Injury Paperwork

Patient Name: ____ Account #: ______________________

Address: ____
Street Address City State Zip

Cell / Home: ___________________________ Email: ____________________________________

SSN or Driver's License #:_________________________ Date of Birth: ________________ ☐Male ☐Female

Email: ____

Employer Name: ____Work Number: ____________________

Date of Injury: ____ Time of Injury ________________

Type of Accident: ☐Auto Accident ☐ Work Injury ☐Slip and Fall ☐ Other _______________________

Describe how the accident occurred: ____

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If auto accident, were you? ☐Driver ☐Passenger ☐Pedestrian

Were you hit from? ☐ Behind ☐ Right Side ☐ Left Side ☐ Front ☐Other

How many people were in your vehicle? ________ Were you aware of the oncoming collision? ☐ YES ☐NO

Year and Model of your vehicle? ________________________ Other car? _________________________

Did you go to the hospital? ☐ YES ☐ NO If yes, which hospital? __________________________________

If yes, by? ☐Ambulance ☐Drove yourself ☐Other What hurts? ____________________________

Have you missed any days from work? ☐ YES ☐ NO If yes, how many days? ________________

____ _______________________________

Patient Signature Date

Your car insurance company will only release this information to you, the policy holder.
Please call *YOUR CARE INSURANCE* provider to obtain this information.

Do you have medical pay? YES NO

Is your medical pay primary or secondary? PRIMARY SECONDARY

If so, how much? $1,000 $2000 $5,000 $10,000

Do you have uninsured motorists policy on your insurance? YES NO

If so, what is the limit?____

PATIENT NAME: ____

NAME OF **YOUR** INSURANCE COMPANY:____

YOUR CLAIM #:____

NAME OF PERSON HANDLING YOUR CLAIM:____

HIS/HER DIRECT PHONE NUMBER:____

DATE OF INJURY:____

Using your medical pay will not raise your care insurance rates.

Please provide the following

- □ Driver's License
- □ Health insurance card
- □ Auto insurance card
- □ Auto Insurance Declaration Page