

# Auto Accident

## Patient's Information:

First Name: \_\_\_\_\_ MI: \_\_\_\_\_ Last Name: \_\_\_\_\_

Date of Injury: \_\_\_\_\_ Circle one: Passenger or Driver

State in which accident occurred: \_\_\_\_\_

## Driver at Fault:

Name of Driver: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Name of Policyholder (if different than driver): \_\_\_\_\_

Address of Policyholder: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone #: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Auto Insurance Company Name: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Insurance Company Contact Name (Adjustor): \_\_\_\_\_

Phone #: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Fax #: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Claim #: \_\_\_\_\_ Policy #: \_\_\_\_\_

## Patient's Auto Insurance (if different than "Driver at Fault"):

Policyholder Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Claim #: \_\_\_\_\_ Policy #: \_\_\_\_\_

Auto Insurance Company Name: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Patient Relationship to Policyholder (circle one): Self Spouse Son Daughter

Other \_\_\_\_\_

## Patient's Attorney Information: (if applicable)

Attorney Name: \_\_\_\_\_ Phone #: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Firm Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_