PERSONAL INJURY/AUTO ACCIDENT
INTAKE

Patient's Name: _____
Patient's Address: _____
_____
City: _____ State: _____ Zip Code: _____
Home Phone: _____ Cell Phone: _____
D.O.B.: _____
D.O.A.:_____

Please bring with you:
A copy of the Police Report, your driver's License, and your auto insurance card.

Have you spoken to an attorney about this case? ___ Yes ___ No
If yes, please give name of the attorney: _____
Phone#_____

NOTE: Before we can schedule your appointment we will have to have the following:

- ❖ Please print, sign and have your attorney sign the medical lien agreement
- ❖ Ask your attorney for a Letter of Representation

INSURANCE COVERAGE: (your insurance carrier)
Name of Carrier: _____
Adjuster's Name: _____
Phone: _____
Address: _____
_____
Claim Number:
Collision coverage amount: _____
Deductible Amount: _____
Liability Coverage: _____
Medical Payment Amount: _____
Uninsured Motorist Coverage Amount: _____
Effective Dates of coverage: _____

INSURANCE COVERAGE (Third Party)
Name of Carrier: _____
Adjuster's Name: _____
Phone: _____
Address: _____
_____
Claim Number:_____
Collision coverage amount: _____
Deductible Amount: _____
Liability Coverage: _____
Medical Payment Amount: _____
Uninsured Motorist Coverage Amount: _____

Patient signature_____ Date_____

Case Manager Signature_____Date_____