PERSONAL INJURY INSURANCE MOTOR VEHICLE ACCIDENT QUESTIONNAIRE

Accident Information

Date of Accident: _________________________ Accident Report Number: _________________________

Location of Accident (Roads, Intersections, City, State): ____

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Were you driving? ○Yes ○No

Was the car that was involved in the accident your vehicle? ○Yes ○No

Were there any passengers in the car? ○Yes ○No

Did you go to the Emergency Room or Urgent Care to be seen? ○Yes ○No

If you received care for the accident, please list where you were seen: ___________________________

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Did you open a claim with your insurance? ○Yes ○No

Do you have comprehensive medical on your auto policy? ○Yes ○No

Patient's Auto Insurance Company

Auto Insurance Company ____

Policy # _________________________ Claim # _________________________

Agent's Name ____

Phone # _________________________

Actively Covered? ○Yes ○No

For Office Staff to Complete

Adjuster's Name____

Phone # _________________________ Fax # _________________________

Uninsured Motorist Coverage ○Yes ○No Comprehensive Medical ○Yes ○No

Direct Payment ○Yes ○No Send Bills as Services Rendered? ○Yes ○No

Attorney on File? ○Yes ○No

Notes ____

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Patient Name _______________________________ Date of Injury _______________

PERSONAL INJURY INSURANCE MOTOR VEHICLE ACCIDENT QUESTIONNAIRE

Patient's Primary Health Insurance Company

Health Insurance Company ____

Address ____

City, State, Zip ____

Policy # ___________________________ Group # ___________________________

Deductible ___________________________ Co-Payment ___________________________

Patient's Secondary Health Insurance Company

Health Insurance Company ____

Address ____

City, State, Zip ____

Policy # ___________________________ Group # ___________________________

Deductible ___________________________ Co-Payment ___________________________

Faulted Party's Auto Insurance Company

Auto Insurance Company ____

Policy # ___________________________ Claim # ___________________________

For Office Staff to Complete

Adjuster's Name____

Phone # ___________________________ Fax # ___________________________

Uninsured Motorist Coverage ○Yes ○No Comprehensive Medical ○Yes ○No

Direct Payment ○Yes ○No Send Bills as Services Rendered? ○Yes ○No

Attorney on File? ○Yes ○No

Notes ____

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Patient Name _________________________________ Date of Injury ________________