

PERSONAL INJURY INFORMATION QUESTIONNAIRE

Patient Name: _____

Date of Accident: _____

1. Name of your automobile insurance company: _____

Name & phone # of your agent: _____

Name of policy holder: _____

Policy # _____

Have you reported this accident to your insurance company? _____

Have you opened a med pay account with your insurance? _____

Claim # _____

Address to send claims to: _____

2. Name of your health insurance company? _____
(Please give us a copy of your insurance card if you would like us to bill them)

3. Have you retained an attorney regarding this accident? _____

Attorney's name & phone #: _____

4. Name of at-fault party's insurance company? _____

Name of policy holder: _____

Name & phone # of the adjuster handling claim. _____

Claim # _____

Have you settled with this company yet? _____