MOTOR VEHICLE ACCIDENT FORM

PATIENT NAME ____

SOCIAL SECURITY # ____

INSURANCE COMPANY ____

BILLING ADDRESS ____

____

CLAIM # ____

CLAIM ADJUSTER ____

INS. CO. PHONE # ____

DATE OF ACCIDENT _________/__________/__________

DATE OF FIRST CONSULTATION_________/_________/_________

IN THE EVENT I FAIL TO PROPERLY COMPLETE THIS FORM FOR INSURANCE FOR INSURANCE FOR THIS INJURY, OR IT IS DETERMINED BY THE INSURANCE COMPANY THAT THIS INJURY IS <u>NOT</u> A RESULT OF THIS ACCIDENT, I ____ HERBY AGREE TO PAY THE PHYSICIAN'S USUAL AND CUSTOMARY FEES FOR SERVICES RENDERED TO THE ABOVE-NAMED CLAIMANT IN THE ABOVE MENTIONED CASE.

DATE ________/_________/________ **SIGNATURE** ____

IF SIGNED BY OTHER THAN THE CLAIMANT, <u>PRINT</u> BELOW: NAME, ADDRESS AND RELATIONSHIP OF THE SIGNER TO THE PATIENT.

NAME AND ADDRESS ____

____

____

RELATIONSHIP ____