AUTOMOBILE INSURANCE FORM

All information is required. Please print clearly.

Patient Name ____ Date of Birth________________________

PLEASE PROVIDE THE FOLLOWING INFORMATION:

Name of Auto Insurance Carrier ________________________________ Policy# ____________________

Is this policy under another person's name ❑ Yes ❑ No

Name of the Policy Holder__________________________________ Phone# ________________________

Address claims are to be sent ____

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Adjuster's Name ______________________________________ Phone# ____________________________

Date of Accident _________________________ Claim# ____

State in which accident occurred _____________________ Was a police report filed? ❑ Yes ❑ No

If you have an attorney, please provide name, address and phone# (this is for our chart information and your attorney will not be billed for services rendered)

Name ____ Phone#_______________________________

Address ____

In the event my claims are denied by the above listed insurance carrier, I understand my private health insurance carrier will be billed. Therefore, for my protection, I will obtain any necessary referrals if applicable. Please provide a copy of your insurance card to the receptionist to be kept in your health records chart.

Health Insurance Carrier _______________________________ Id# _________________________________

Insured's Name ____

By signing this form I understand that I am responsible for the payment of all services rendered should my claims be denied by my automobile insurance carrier or my health insurance carrier or both.

I have carefully completed and read the statement above and fully understand the contents.

Patient or Guardian Signature ____________________________________ Date signed ______________