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## ACCIDENT REPORT

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Date of Accident \_\_\_\_\_ Type of Accident \_\_\_\_\_  
(auto accident, personal injury, etc.)

If personal injury – place of accident \_\_\_\_\_

Patient's auto insurance (if applicable) \_\_\_\_\_

Policy# \_\_\_\_\_ Billing Address \_\_\_\_\_

Policy Holder's Name \_\_\_\_\_

Name of Attorney (if applicable) \_\_\_\_\_

Phone \_\_\_\_\_ Address \_\_\_\_\_

Description of injury \_\_\_\_\_

\_\_\_\_\_  
\*Please note: The above information is necessary prior to treatment; otherwise patients are responsible for payment at the time of service.

PERSONAL INJURY: Letter of protection/lien information, etc. must be submitted by the patient's attorney.

AUTO ACCIDENT: If your auto insurance does not cover your medical expenses, we will submit a claim to your health insurance if such insurance is available. Otherwise, payment is expected at the time of service.

Patient/Guardian's Signature \_\_\_\_\_ Date \_\_\_\_\_