Auto Accident Insurance Information

Plumsteadville Family Practice

PATIENT NAME: _____ SOCIAL SECURITY#: _____

DATE OF BIRTH: _____

ADDRESS: _____

DATE OF ACCIDENT AND TIME: _____ STATE OF ACCIDENT: _____

BRIEFLY DESCRIBE HOW ACCIDENT HAPPENED: _____

_____

_____

PATIENT'S AUTO INSURANCE COMPANY: _____

AUTO INS COMPANY ADDRESS: _____

AUTO INS. COMPANY PHONE #_____

SUBSCRIBER OF POLICY: _____ POLICY NUMBER: _____

IF PATIENT IS A MINOR, RESPONSIBLE PARTY NAME & ADDRESS: _____

_____

CLAIM NUMBER: _____

AUTO INSURANCE AGENT: _____

AGENT'S ADDRESS: _____

AGENT'S PHONE NUMBER: _____

_____ I understand that the physician is to file directly to my insurance carrier and I am not responsible for expenses incurred until my medical coverage limitation is exceeded. I also give my permission to Plumsteadville Family Practice to release my medical records (pertaining to auto accident only) to my auto insurance carrier upon request.

_____ I do not intend to report this accident to my insurance carrier. I understand my health insurance will be notified and I may be responsible for expenses incurred at this office as a result of the above accident.

SIGNATURE: _____ DATE: _____