Automobile Accident Information

Please complete all information below.

Patient Information

Today's Date: ____ DOB: ____

Patient's Name: ____ Phone: ____

Accident Information

Date of Accident: ____

Location of Accident: ____

Patient's Vehicle Make: ____ Model: ____ Year: ____

Other Vehicle Involved: ____ Model: ____ Year: ____

Insurance Information

Auto Insurance Company: ____

Claim Number: ____

Do you have **Personal Injury Protection** (PIP) as part of your insurance policy? ☐ Yes ☐ No

If "Yes," are your PIP benefits exhausted? ☐ Yes ☐ No

Insurance Claim Manager: ____ Phone: ____

Other Party's Insurance Co: ____

Other Party's Claim Num.: ____

Were you at fault for this accident? ☐ Yes ☐ No

Do you have an attorney? ☐ Yes ☐ No

If "Yes," Attorney's Name: ____ Phone: ____

Do you have regular health insurance? ☐ Yes ☐ No

Health Insurance Company: ____

Health Insurance ID Num.: ____

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Form 00005 – Rev. 021417