Auto Accident Information Form

To be completed by patient

Patient Name: _____

Name of **My** Auto Insurance Carrier: _____

My Auto Insurance's billing address:

_____

_____

My Auto Insurance Adjustor Name & Phone Number:_____

My Auto Insurance Claim Number: _____

Has a claim been filed with this auto insurance? Yes No

Other Driver's Name: _____

Other Driver's Auto Insurance Carrier: _____

Other Auto Insurance's billing address:

_____

_____

Other Carrier's Adjustor Name & Phone Number: _____

Other Carrier's Claim Number: _____

Has a claim been filed with this auto insurance? Yes No

Do You have legal representation? Yes No

Attorney Name: _____

Attorney address & phone number: _____

_____

By signing the below, I understand that since I have legal representation, a physician's lien will be filed with the auto insurance(s) and my attorney. My auto insurance and the other party's auto insurance will be billed for payment of the expenses incurred. In filing a lien, The Spine Center agrees to wait until my case settles to collect payment of my bill.

Sign:_____ Date:_____