Auto Accident Information Form

To be completed by patient

Patient Name: ______________________________ Date of Accident: _______________

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

My Auto Insurance's billing address:

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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:

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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 Firm name, address & phone number: _______________________

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By signing 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:___________________