Automobile Accident Information

Please complete all information below.

ORTHOWASHINGTON

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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