

## ACCIDENT FORM

**It is the responsibility of the patient to inform our office of any and all insurance information so that we may file your claim correctly. You will be responsible for any unpaid claims due to incomplete or incorrect information submitted to this office.**

Is the reason for your visit due to an injury or accident \_\_\_\_\_ YES \_\_\_\_\_ NO

Date of injury or accident \_\_\_\_\_

AUTO WORK SCHOOL HOME OTHER

Was a third party responsible for your accident \_\_\_\_\_ YES \_\_\_\_\_ NO

Name, address, and phone number of individual or company \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Claim number \_\_\_\_\_ Name of Adjuster \_\_\_\_\_

Date you stopped working \_\_\_\_\_

Employer or supervisor \_\_\_\_\_

Work phone number \_\_\_\_\_

Description of accident \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Date your company or supervisor was notified \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_