

**MOTOR VEHICLE ACCIDENT INFORMATION SHEET
PATIENT INFORMATION**

Name: _____ Birth Date: _____ Social Security #: _____

Address: _____ Telephone #: _____

MOTOR VEHICLE INSURANCE INFORMATION

Motor Vehicle Insurance Carrier: _____

Carrier Address: _____

Telephone #: _____ Adjuster's Name: _____

Verified (office use): _____ Claim Number: _____

INJURY INFORMATION

Date of Injury: _____ Time: _____

Brief Description: _____

Were you seen in a hospital after the accident? _____ Yes _____ No

If yes, name of Hospital: _____ Location: _____

Other Doctor's Name: _____ Location: _____

Were x-rays taken? _____ Yes _____ No Other Tests _____ Yes _____ No

If yes, please list tests and results: _____

AUTHORIZATION

I hereby authorize Bergen Family Practice of North Jersey to furnish information to insurance carriers concerning my illness and treatments. I understand that I am responsible for any amount not covered by insurance. A copy of this authorization may be used in place of the original.

Signed: _____ Date: _____