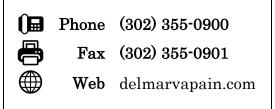


MOTOR VEHICLE ACCIDENT INTAKE FORM



AUTO ACCIDENT INFORMATION

Patient's Name:	Date of Birth:
PLEASE PROVIDE THE FOLLOWING INFORMATION:	
Auto Insurance Company:	
Address:	
Claim #:	Adjustor Name:
Date and State of Accident:	Adjustor Phone #:
Briefly describe the accident and injuries:	
briefly describe the accident and injuries	
-	
If you have an attorney representing you on this case, please provide the following:	
if you have an attorney representing you on this ease, please provide the following.	
Attorney's Name:	
Attorney's Phone Number:	
In the event my claims are denied from the above listed insurance carrier, I understand my personal health insurance will be billed. Therefore, for my protection, I will obtain the necessary referrals if applicable.	
I understand that I am responsible for any payment of all services rendered should my claims be denied.	
Signature: X	Date: