MOTOR VEHICLE ACCIDENT INTAKE FORM

DELMARVA PAIN AND SPINE CENTER

Phone (302) 355-0900
Fax (302) 355-0901
Web delmarvapain.com

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:

If you have an attorney representing you on this case, 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: