



1623 NE BROADWAY
PORTLAND, OR 97232
503-286-4400
FAX: 503-286-4944

Motor Vehicle Accident Intake Form

Patient's Full Name _____

Street Address _____

City, State, Zip _____

Birth date ____/____/____ Age _____

Phone: (home) _____ (cell) _____ (work) _____

Marital Status (check one): Single _____ Married _____ Divorced _____ Widowed _____

Email Address _____

How did you hear about us? _____

In case of emergency please contact: Name _____ phone: _____

BY WAY OF SIGNATURE, I AUTHORIZE TREATMENT AND GIVE PERMISSION TO EXCHANGE INFORMATION WITH MY INSURANCE COMPANY/S TO OBTAIN PAYMENT. IF MY PERSONAL INJURY PROTECTION INSURANCE IS EXHAUSTED OR FAILS TO PAY, I AM RESPONSIBLE FOR ALL BALANCES ON MY ACCOUNT. I UNDERSTAND THAT MISSED APPOINTMENT FEES (\$100) ARE NOT BILLABLE TO INSURANCE AND ARE MY RESPONSIBILITY.

Patient Signature _____ Date _____

Parent or Guardian Signature _____ Date _____

PIP Carrier: _____

Contact Name: _____

Contact Phone Number: _____

Claim Number: _____

Fax number for insurance: _____

Date of Accident: _____

City/state accident where occurred: _____

Rise Health

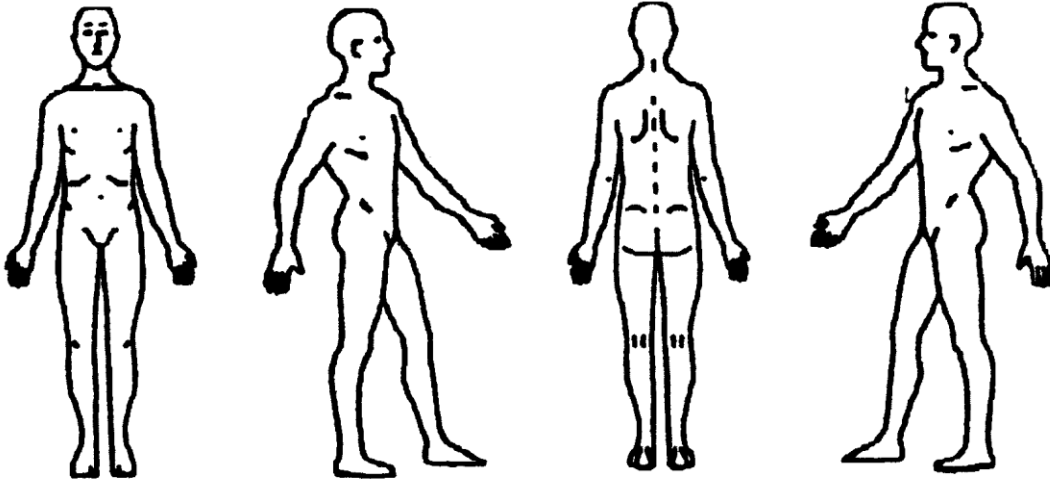
Who was driving? _____

Describe what happened: _____

Did you go to the Hospital? _____ Hospital Name _____

Were x-rays taken? _____

Please mark all areas where injury/pain occurred:



Do you have other health problems or concerns? _____

If you have an attorney please provide the following information:

Name: _____

Firm Name: _____

Address: _____

Phone: _____