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: __________

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?____

____

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If you have an attorney please provide the following information:

Name: ______________________________

Firm Name: ______________________________

Address: ______________________________

____

Phone: ______________________________