DEKALB HEALTH
MEDICAL GROUP

AUTO ACCIDENT INSURANCE FORM

Patient Name: _____ DOB: _____ MRN: _____

Date & time of Auto Accident: _____ State Where Auto Accident Occurred: _____

Your Auto Insurance Carrier Name: _____

Address: _____

C/S/ZIP: _____

Phone: (_____) _____-_____ Policy Number: _____

Claim Number (if available): _____

Policy Holder Name _____

Date of Birth: _____ Social Security Number: _____

Other Person's Auto Insurance Carrier Name: _____

Address: _____

C/S/ZIP: _____

Phone: (_____) _____ -_____ Policy Number: _____

Claim Number (if available): _____

Policy Holder Name _____

Date of Birth: _____ Social Security Number: _____

Where should we send your claims? (Check one)

My insurance company _____ The other person's insurance company _____

Charges related to my auto accident will be filed to the above Auto Insurance Carrier(s) as I have indicated. I understand that I will be responsible for the charges if the balance is not paid within sixty (60) days of today's date.

_____ _____

Signature of Patient or Parent/Guardian Date

(For Office Use Only)++

Account Number: _____ Date of contact with insurance(s): _____

Notes:_____

_____

_____

*****This form must be returned within 7 days of the office visit***Needs to be returned by:_____**