Accident Claim Information

Complete this form in its entirety. The requested information is required to begin treatment. If any information is missing, we will not be able to bill your insurance and payment will be due in full at the time of service.
Please note our office is unable to bill third party insurance.

PATIENT DEMOGRAPHICS

Name: _____ **Suffix:** Jr. Sr. II III
Last MI First

Patient's SSN: _____ **Sex:** M F **Birthdate:** _____ **Age:** _____

INSURANCE

Insurance Carrier: _____ **Policy Number:** _____

Policy Holder: _____ **Policy Holder is:** SELF SPOUSE PARENT OTHER

Claim Number: _____ **Date of Accident:** _____

Vehicle Type: CAR MOTORCYCLE BICYCLE ANIMAL

Your Role: DRIVER PASSENGER PEDESTRIAN RIDER

Adjuster: _____ **Phone:** _____ **Ext:** _____

ATTORNEY DEMOGRAPHICS

Attorney: _____

Physical Address: _____
Street City State Zip

Attorney Phone: _____ **Attorney Contact:** _____

TREATMENT HISTORY

Have you had any previous treatment for your current condition? *YES NO* ***If YES, where:***

Provider: _____ **Phone:** _____

Have you had any previous diagnostic imaging for your current condition? *YES NO* ***Where:***

Facility: _____ **Type:** MRI CT Scan X-Ray Other

California insurance regulations require that Med Pay be billed as the primary insurance for all auto claims prior to the use of private health insurance. I understand that knowingly withholding or falsifying information is a violation of the law. I understand that I will be financially liable for any services rendered which are not covered or paid by my auto and health insurance plan(s). The above information is true and correct to the best of my knowledge. Should any of the information pertaining to my claim or care change, I will notify Physical Therapy Specialists without delay at (805) 473-7499.

Signature: _____ **Date**: _____