Personal Injury Case Information Form

Section A: Patient Information

Last Name:		First Name:	
Date of Birth:	SSN:		Date of Injury:
Address:			

1. **Is this injury related to a motor vehicle accident, slip and fall or the negligence of another person? ☐ YES ☐ NO**
   If YES, please complete section C. If you have retained an attorney, please also complete section D.

Section C: Personal Injury Lawsuit

In the space below, please provide a narrative of how your injury occurred. **If additional space is needed, please use the back side of this page.**

Insurance Information			
Insurance Company:		Claim#:	
Adjuster/Name of Contact Person (at Insurance Company):			
Phone#:	Fax#:		
Address:	City	State:	Zip:
Name of Insured:			
Is there more than one claim that pertains to this date of injury? ☐ **YES** ☐ **NO** If YES, please provide the same information (listed above) on the back side of this sheet.			

2. **Have you signed a retainer agreement for legal representation? ☐ YES ☐ NO**
   If YES, please complete section D.

Section D: Attorney Information

Insurance Information			
Law Firm Name:			
Attorney Name:	Assistant Name (If applicable):		
Phone#:	Fax#:		
Address:	City	State:	Zip:

All information submitted on this form is true to the best of my knowledge. I understand any incorrect information submitted may result in a delay of my treatment. It is my responsibility to submit any changes to my claim information in a timely manner. I understand that I am financially responsible for all charges of services rendered to me including the balances of claims denied by my Insurance Company, any Third Party Payer and/or attorney.

____ _________________________

Signature Date