Arrowhead HEALTH CENTERS™

PERSONAL INJURY CASE INFORMATION

PATIENT INFORMATION

Patient Name: ______________________________ DOB: ______________

SSN: ____________________ Phone: ____________________ ☐ Home ☐ Work ☐ Cell

Address: ____

E-mail Address: ____

AUTO INSURANCE

☐Med Pay ☐Underinsured/Uninsured Motorist

Company Name: ______________________________ Phone: ______________

Mailing Address: ____

Policy Number: ______________________________ $ Limit: ______________

Adjuster: ____

Extension: ____________________ Claim Number: ____________________

3RD PARTY INSURANCE

Company Name: ______________________________ Phone: ______________

Mailing Address: ____

Adjuster: ____

Extension: ____________________ Claim Number: ____________________

If the insured under the policy is someone other than the owner of the premises responsible for the accident, please state the basis for asserting coverage under the policy:

Adjuster: ______________________________ Phone: ______________

If there exists any other policy(ies) of insurance which may afford coverage for the patient's damages, please provide the information requested above for each such policy on a separate attached sheet.

Please describe any pending issues regarding coverage under the policy(ies) listed above:

____

____

HEALTH INSURANCE

Company Name: ______________________________ Phone: ______________

Mailing Address: ____

ID Number: ____________________ Group Number: ____________________

Policy Holder's Name: ______________________________ SSN: ______________

______________________________ ______________________________

Patient Signature **Today's Date (MM/DD/YYYY)**

Employee: ______________________________ ______________________________