New Patient Intake

Date New Patient: _____
Date Seen in Billing: _____
Patient Name: _____ DOI: _____
Where did the accident occur? _____
Does patient have pictures? Y ____ N ____ If so, attach pictures to this intake sheet
ER visit? Name of ER: _____

LIABILITY (AT-FAULT) INSURANCE

Ins. Co.: _____
Send Claims To: _____
Claim #: _____ Adj: _____
Phone: _____ Fax: _____
Driver: _____ Policyholder/Number: _____
Notes: _____
_____

LIABILITY (AT-FAULT) INSURANCE

Ins. Co.: _____
Send Claims To: _____
Claim #: _____ Adj: _____
Phone: _____ Fax: _____
Driver: _____ Policyholder/Number: _____
Notes: _____
_____

PERSONAL (MED-PAY/UM

Ins. Co.: _____
Send Claims To: _____
Claim #: _____ Adj: _____
Phone: _____ Fax: _____
Driver: _____ Policyholder/Number: _____
MedPay: Y___ N ___ Limit: _____ UM: Y___ N ___ Limit: _____
Did you contact Patient's Insurance agent to verify MP or UM? _____
Agent's Name: _____
Agent Phone Number called: _____ Dated called Agent: _____
Notes: _____
_____

SMVA: _____
Name of Attorney: _____ PH: _____
Driver: Y N Passenger: Y N Previous Injury Claim: Y N
Have you given a statement to the at-fault insurance company? Yes No
Have you settled your property damage claim? Yes No Amt of Settlement _____
How much property damage did your car incur? _____
Was your car towed? _____
Did you lose consciousness? _____
____ Preferred method of contact? Home/Work/Cell Number: _____
____Discussed insurance, MP, UM, and Physician's Lien with patient _____ Date: _____