biomechanix
PHYSICAL THERAPY

Auto Accident/Personal Injury Form

This form must be filled out COMPLETELY.

Patient Name: _____

Patient's Auto Insurance Company Name: _____

Policy Number: _____ Date of Accident: _____

City and County of Accident: _____

Adjuster Name: _____ Claim Number: _____

Phone Number: _____ Extension: _____

Fax Number: _____

At Fault's Auto Insurance Company Name: _____

Insured's Name: _____ Policy Number: _____

Adjuster Name: _____ Claim Number: _____

Phone Number: _____ Extension: _____

Fax Number: _____

Law Firm Name: _____

Case Number: _____

Attorney Name: _____

Phone Number: _____ Extension: _____

Fax Number: _____

Patient Signature: _____

Notice: Please inform the front office if you are planning to do a 3rd party lien. There will be additional patient and attorney paperwork for this service.