Peace Valley Internal Medicine, P.C.

Auto Accident Insurance Information

PATIENT NAME: _____ DATE OF BIRTH: _____

ADDRESS: _____

DATE OF ACCIDENT AND TIME: _____ STATE OF ACCIDENT: _____

AUTO INS COMPANY: _____

AUTO INS COMPANY ADDRESS: _____

AUTO INS. COMPANY PHONE #_____

POLICY NUMBER: _____

CLAIM NUMBER: _____

AUTO INSURANCE AGENT: _____

AGENT'S ADDRESS: _____

AGENT'S PHONE NUMBER: _____

_____ I understand that the physician is to file directly to my insurance carrier and I am not responsible for expenses incurred until my medical coverage limitation is exceeded. I also give my permission to Peace Valley Internal Medicine to release my medical records (pertaining to auto accident only) to my auto insurance carrier upon request.

SIGNATURE: _____ DATE: _____