alliant
physical therapy &
integral medicine

MOTOR VEHICLE ACCIDENT INFORMATION SHEET

Please check all that apply:

☐ PIP (Your Auto Insurance) ☐ Personal Medical ☐ Third Party Insurance (Other Vehicle Involved)

I was: ☐ Driving my car ☐ Driving another's car ☐ Passenger ☐ Pedestrian

Your Name: _____

Date and Time of Accident: _____

Place of Accident: Street/Intersection, City, State: _____

Description of Accident (rear-end, broadside, head-on, etc): _____

_____

Your Auto (PIP) Insurance Company: (or insurance company of the owner of vehicle in which you were a passenger or driver)

Claim Number: _____Claim Adjuster: _____

Claim Adjuster Phone: _____Fax: _____

Insurance Company Name: _____

Address: _____ City, State, Zip: _____

Insured's Name: _____

Insured's Address, City, State, Zip: _____

Third Party Insurance Company (Other Vehicle Involved):

Claim Number: _____Claim Adjuster: _____

Claim Adjuster Phone: _____Fax: _____

Insurance Company Name: _____

Address: _____ City, State, Zip: _____

Insured's Name: _____

Insured's Address, City, State, Zip: _____

Attorney:

Name: _____ Firm: _____

Address: _____ City, State, Zip: _____

Phone: _____Fax: _____

Paralegal: _____ Phone: _____

Lien on file with Attorney? ☐ Yes ☐ No ** If yes, please provide copy **