1623 NE BROADWAY
PORTLAND, OR 97232
503-286-4400
FAX: 503-286-4944

Motor Vehicle Accident Intake Form

Patient's Full Name____

Street Address____

City, State, Zip____

Birth date _____/______/______ Age___________

Phone: (home)______________________________ (cell)_______________________ (work)_______________

Marital Status (check one): Single__________Married______ Divorced______ Widowed_____

Email Address ____

How did you hear about us?____

In case of emergency please contact: Name ________________________________ phone: ______________

BY WAY OF SIGNATURE, I AUTHORIZE TREATMENT AND GIVE PERMISSION TO EXCHANGE INFORMATION WITH MY INSURANCE COMPANY/S TO OBTAIN PAYMENT. IF MY PERSONAL INJURY PROTECTION INSURANCE IS EXHAUSTED, I AM RESPONSIBLE FOR ALL BALANCES ON MY ACCOUNT. I UNDERSTAND THAT MISSED APPOINTMENT FEES ($50) ARE NOT BILLABLE TO INSURANCE AND ARE MY RESPONSIBILITY.

Patient Signature____ Date ________________

Parent or Guardian Signature____ Date ________________

Name:____ Date:____________________________

PIP Carrier:____

Contact Name:________________________________ Contact Phone Number:_______________

Claim Number:__________________________ Fax number for insurance:____________________

Date of Accident: _______________________ City/state accident where occurred: ___________

Who was driving?____

Describe what happened:____

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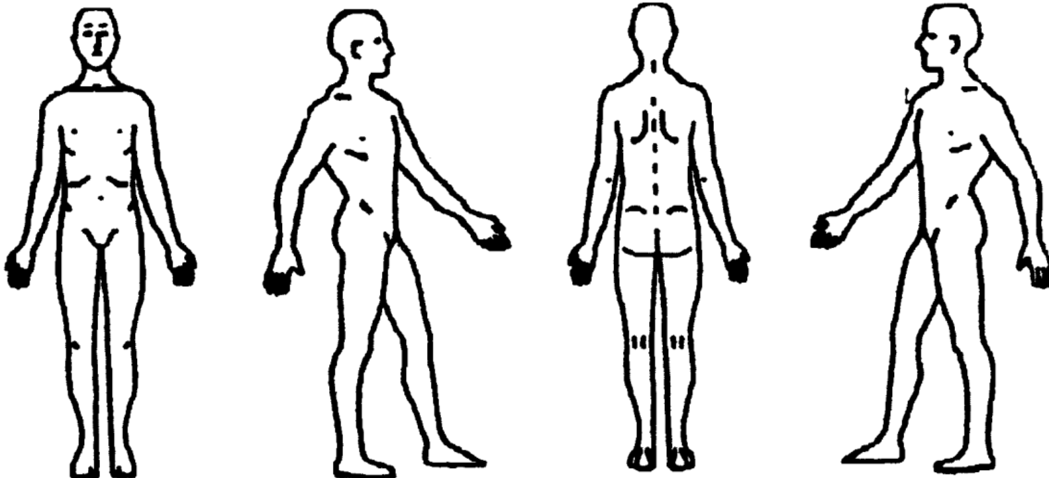
Did you go to the Hospital? ______________Name of Hospital_____________________________

Were x-rays taken? ____

Please mark all areas where injury/pain occurred:



Do you have other health problems or concerns?____

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