6200 E. Central • Wichita, KS 67208
(316) 858-5800 • Fax (316) 858-5850

AUTOMOBILE ACCIDENT FORM

PATIENT NAME ____
DATE OF BIRTH ____
SOCIAL SECURITY NUMBER ___________________________

ACCIDENT CLAIM NUMBER ____________________________
DATE OF ACCIDENT ___________________ TIME OF ACCIDENT ____________
EXACT LOCATION OF ACCIDENT ____
____

HAVE YOU NOTIFIED YOUR INSURANCE AGENT? ________________________

NAME OF **YOUR** INSURANCE COMPANY _________________________________
AGENT'S NAME ____
MAILING ADDRESS ____
____

TELEPHONE NUMBER(S) ____

HAVE YOU RECEIVED PRIOR TREATMENT FOR THIS ACCIDENT? __________
IF YES, PLEASE GIVE NAME OF PROVIDER _______________________________
DATE OF TREATMENT ______________________________________
TYPE OF CARE RECEIVED ___________________________________
____

DESCRIBE THE ACCIDENT IN YOUR OWN WORDS
____
____
____
____

PLEASE STATE ANY INJURIES RESULTING FROM THIS ACCIDENT
____
____

HAVE YOU RETURNED TO WORK SINCE THE ACCIDENT? __________________
IF YES, WHEN? ____

PATIENT SIGNATURE ____________________________DATE__________________

RON C. BROWN, MD CHRIS N. BRUNNER, MD DORIS C. BUTLER, MD STEVE W. DAVIS, MD CONNIE A. DAVIS, MD
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