# Patient Insurance Profile

Patient Name ______________________ Date of accident ______________

Legal representative ______________________ Rep. Phone # ______________

Total # of vehicles in accident ______________

I was ( )Driving ( )Passenger IN ( )My own car ( )Someone else's car

( )I was given citation for being at fault ( )The other driver was given citation for being at fault

## YOUR AUTO INSURANCE COMPANY INFORMATION:

Insurance Company Name ______________________________________

Phone # ______________________ Fax # ______________________

Address ______________________________________

Claim # ______________________ Adjusters Name ______________________

I have Med Pay on my policy ( )Yes ( )No Limits ______________

## YOUR HEALTH INSURANCE INFORMATION:

Insurance Company Name ______________________________________

Phone # ______________________ Fax # ______________________

Address ______________________________________

Policy # ______________________ Limits ______________________

## ADVERSE AUTO INSURANCE COMPANY INFORMATION:

Insurance Company Name ______________________________________

Phone # ______________________ Fax # ______________________

Address ______________________________________

Claim # ______________________ Adjusters Name ______________________