Nebraska Medicine

CLARKSON FAMILY MEDICINE

# AUTO ACCIDENT FORM

NAME: ______________________________________________________ DOB: ________________________

ADDRESS: ________________________________________________________________________________

PHONE#: ________________________ SS#: _____ / _____ / _______ Date of Accident: _____/_____/_____

First seen for MVA: _____/_____/_____ by ER/Physician: ____________________________________

Name of person responsible for the accident: ________________________________________________________

Do you anticipate a lawsuit as a result of this accident? Yes _____ No _____ Attorney Name: ______________

Address: ______________________________________________ Phone #: ______________________________

**PATIENT**/Auto Insurance Information: Claim #: _____________________________

Name of Auto Insurance: ____________________________________ Spoke with: _________________________

Address of Insurance Company: __________________________________________________________________

________________________________________________________________________________________________

Policy #: ________________________________________ Phone #: ____________________________________

**SECONDARY** /3rd Party Liability: Claim #: ________________________

Name of Auto Insurance: ____________________________________ Spoke with: _________________________

Address of Insurance Company: __________________________________________________________________

________________________________________________________________________________________________

Policy #: ________________________________________ Phone #: ____________________________________

**PRIVATE** Insurance Information: Name of Insurance: __________________________________

Address of Insurance Company: __________________________________________________________________

________________________________________________________________________________________________

Policy #: ______________________________ Group #: ___________________ Phone #: __________________

---

I UNDERSTAND THAT AS A SERVICE TO ME, CLARKSON FAMILY MEDICINE WILL FILE THE CHARGES TO THE AUTO INSURANCE LISTED ABOVE, HOWEVER, CLARKSON FAMILY MEDICINE WILL NOT BE OBLIGATED TO WAIT FOR THE ACCIDENT TO BE SETTLED BEFORE PAYMENT IS OBTAINED. I WILL PAY FOR THESE CHARGES AT TIME OF SERVICE.

SIGNATURE: ____________________________________________

DATE: _____/_____/_____