MOTOR VEHICLE ACCIDENT PATIENT INFORMATION

Date of accident: _____ / _____ / _____
Day Month Year

Claim / Policy# _____

Car Insurance Company: _____

Car Insurance Address: _____
Street

_____
City

_____
Postal Code

Car Insurance Adjustor: _____

Car Ins. Adjustor Phone #: ____(____)_____X_____

Car Ins. Fax Number: ____(____)_____

Do You Have any Private or Extended Health Insurance? YES / NO

If Yes, information below must be provided:

Name of Private Insurance : _____

Private Ins. Address: _____
Street

_____
City

_____
Postal Code

Telephone Number #: __(____)_____X_____

Is there a lawyer involved? YES / NO

Lawyer Name: _____

Lawyer Phone Number: __(____)_____X_____

91 Rylander Boulevard, Suite 204, Scarborough, Ontario M1B 5M5
Tel: 416-284 8973 Fax: 416-284-9485