NO FAULT INFORMATION SHEET

ALL INFORMATION MUST BE COMPLETE IN ORDER TO PROCESS YOUR CLAIM

Today's Date: ____________________

Patient's Name: ____

Name of the Insured: ____

Owner of Vehicle: ____

Name of Insurance Company: ____________________________________

Address: ____

City: __________________ State: _________ Zip: ___________

Policy Number: _________________________ Claim Number: ______________________

Date of Accident: ________________________

Were you: Driving, A Passenger, or a Pedestrian? (please circle)

Please give a brief description of the accident: ______________________________________

____

Describe the injury in which you are seeing the Doctor for: ____________________________

____

Did you go to the Hospital: yes / no Which Hospital: ______________________________

How long was your stay?: ____