Health Clinic, Inc. dba Metromedic

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ACCIDENT REPORT / MOTOR VEHICLE REPORT

1. Patient Name:_____ Date:_____

   Address _____

   CITY _____ State _____ Zip _____

   Home Telephone #_____ Work telephone #_____

   Date of Birth: _____ SS # _____

2. **DATE OF INJURY:**_____ **TIME:** _____ **(AM / PM)**

3. **CHIEF COMPLAINT:**_____

   _____

4. How did the accident happen? _____

   _____

5. Where did the accident happen?_____

   _____

6. Accident report filed? (Circle One) YES NO

7. Were you treated in the Emergency Room / Hospital? (Circle One) YES NO

8. Local insurance agent's NAME: _____

   Address: _____

   _____ Tel: _____

9. Who is the insured party? _____

   Address: _____

10. Do you have medical bill coverage? **We need a copy of your insurance card TODAY**

11. Are you insured in MA or RI (Circle One) YES NO

12. Were you wearing a seat belt? (Circle One) YES NO

13. Please complete the following if an attorney is handling this claim.

    Attorney's Name: _____ Tel #_____

14. Were you the operator _____ or passenger (Front / Rear) _____ in the car?

15. Operator's Name as listed on Insurance:_____

    Operator's Insurance Co. _____

    Please provide a copy of operator's insurance

FOR PASSENGERS – PLEASE BE SURE TO FILL IN #10 AND #15

FOR OPERATORS – PLEASE BE SURE TO FILL IN #8

_____ **Patient Signature**