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Auto Insurance P.I.P. Intake Form

Patient:_____

Address:_____State:_____Zip:_____

Date of Birth:_____Phone:_____Email:_____

Occupation:_____How long?_____

Emergency Contact:_____Phone:_____

Insurance Company:_____Group #_____

Policy #:_____Claim #:_____

Name of Adjuster:_____

Date of Incident:_____

Referring Doctor:_____Phone#:_____

Address:_____State:_____Zip:_____

Attorney:_____Phone #:_____

Address:_____State:_____Zip:_____

How will payment be made?

_____Auto Insurance _____Credit Card

_____Major Medical _____Other

- Was this case related to: _____Work _____Auto _____Other
- How did it happen? _____

  _____
- Has the insurance company been notified? _____
- If work related, has your employer been notified? _____
- Have you seen treated or seen by a doctor for this occurrence? _____
- Has your doctor prescribed or referring you to receive massage therapy? _____
- What makes your symptoms better? _____

  _____
- What makes your symptoms worse? _____

  _____
- Have you been treated before for the same condition? _____
- Recent surgeries: _____

  _____
- Pre-existing conditions that may be related to this recent injury? _____

  _____
- Do you have No-Fault P.I.P benefits? _____
- Are there benefits left? _____
- Do you have a deductible?_____The amount? _____
- Has it been met yet? _____If not, how much deductible is left?_____
- What percentage does your insurance cover? _____
- What are the policy limits? _____
- Were you struck from: Behind _____ Front _____ R. Side _____ L. Side _____
- Other accident details: _____
- Did you feel pain immediately?_____
- If no, when and where did you first start feeling pain? _____

  _____
- Since the injury are your symptoms: Getting worse? _____ Improving? _____
- Staying the same? _____ Explain: _____
- Were you the: Driver?_____ Passenger?_____ Pedestrian? _____