Integrated Health & Wellness Centre

40 Wynford Dr, Suite 212, North York, Ontario, M3C 1J5

Motor Vehicle Accident – Information Form

Today's Date: ______________________

Patient's Name ____
Sex: Male or Female ________________________ Birth Date ___________________________
Address ____
City ____________________________ Province ________________________
Postal Code ____________________________
Phone Number (H) ____________________________ (W) ___________________________
Do you have a medical Referral: Yes / No MD's Name ______________________________

ACCIDENT

Policy # _____________________________ Claim # _________________________________
Date of Motor Vehicle Accident _______________________ Time ________________
Main Intersection accident occurred ____

INSURANCE INFORMATION

Car Insurance ______________________ City/Town/Branch Office ____________________
Address ____
Adjuster Name ____
Phone # _________________________________ Fax # ____________________________
Policy Holder: □ Same as Applicant above □ Other than Applicant above
Policy Holder's Full Name ____
Did you receive the Accident Benefits Package? **Yes / No**
Did you complete it and send it in? **Yes / No**

Extended Health Care Coverage: Other Insurer

Insurer's Name ____
Insurance Plan or Policy # ____
Name of Plan Member ____
Other Insurer's Identifier ____
Were you employed at the time of the accident? (Yes / No) ___________________________

Does your spouse have Extended Health Care Coverage? **Yes / No**
Spouse's Name ____
Insurance Plan or Policy # ____
Name of Plan Member ____
Other Insurer's Identifier ____

LAWYER

Legal Rep. Name ____
Address ____
City ____________________________Province______________________
Postal Code ____
Phone # ____
Fax # ____