

Integrated Health & Wellness Centre

158 Elgin Mills Rd West, Richmond Hill, Ontario L4C 4M2

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 # _____