

**BOULDER OSTEOPATHIC CENTER  
AUTOMOBILE ACCIDENT INFORMATION**

PATIENT NAME \_\_\_\_\_

AUTO ACCIDENT (Please describe in your own words) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

DATE OF ACCIDENT: \_\_\_\_\_

INJURIES: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

WERE YOU HOSPITALIZED? YES / NO IF YES, WHERE: \_\_\_\_\_

DATES HOSPITALIZED \_\_\_\_\_

MISSED WORK DUE TO THIS AUTO ACCIDENT? YES / NO IF YES, LIST DATES: \_\_\_\_\_

WERE THERE ANY WORK OR OTHER REGULAR DUTIES YOU WERE UNABLE TO PERFORM (LIST): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

PLEASE LIST ANY OTHER AUTOMOBILE ACCIDENTS YOU WERE INVOLVED IN, INCLUDING DATES: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

HAVE YOU HAD AN INDEPENDENT MEDICAL EXAMINATION? YES / NO IF YES, WHEN? \_\_\_\_\_  
LIST ALL DOCTORS W/ THEIR DIAGNOSIS AND TREATMENT, X-RAYS, PHYSICAL/OCCUPATIONAL/MESSAGE THERAPY,  
PAIN CLINIC, AND ANY OTHER INFO RELATED TO THIS ACCIDENT: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

YOUR ATTORNEY NAME: \_\_\_\_\_ PHONE: \_\_\_\_\_

FAMILY DOCTOR NAME: \_\_\_\_\_ PHONE: \_\_\_\_\_

Draw mechanics of Accident using: x = you o = 1st vehicle,  
n = other object, T = truck, B = bus, P = pedestrian  
\_\_\_\_\_ ; \_\_\_\_\_ : \_\_\_\_\_ ; \_\_\_\_\_  
..... ; ..... ; .....  
\_\_\_\_\_ ; \_\_\_\_\_ : \_\_\_\_\_ ; \_\_\_\_\_

I UNDERSTAND AND AGREE IF FOR ANY REASON MY AUTO INSURANCE DOES NOT PAY, I AM RESPONSIBLE  
FOR PAYMENT OF ALL SERVICES RENDERED AT BOULDER OSTEOPATHIC CENTER IN FULL.

YOUR SIGNATURE \_\_\_\_\_ YOUR PRINTED NAME \_\_\_\_\_ TODAY'S DATE \_\_\_\_\_

**NOTIFICATION OF ASSIGNMENT OF PAYMENT**

I Request All Bills for Medical Services Rendered by this Office be Paid Directly to Boulder Osteopathic Center, LTD.

YOUR SIGNATURE \_\_\_\_\_ YOUR PRINTED NAME \_\_\_\_\_ TODAY'S DATE \_\_\_\_\_

**YOUR AUTO INSURANCE INFORMATION (Required):**

NAME OF INSURED: \_\_\_\_\_

POLICY NUMBER: \_\_\_\_\_ CLAIM NUMBER: \_\_\_\_\_

NAME OF AUTO INSURANCE COMPANY: \_\_\_\_\_

MAILING ADDRESS OF AUTO INSURANCE: \_\_\_\_\_

NAME OF ADJUSTER: \_\_\_\_\_ PHONE: \_\_\_\_\_

DO YOU HAVE MEDPAY ON THIS AUTO POLICY? YES / NO

HAVE YOU RECEIVED AUTHORIZATION FOR TREATMENT? YES / NO

DO YOU HAVE HEALTH INSURANCE YOU'D LIKE US TO SUBMIT YOUR CLAIMS IF YOUR AUTO DOES NOT PAY? YES / NO  
*(If YES, Provide us with a copy of your insurance card & fill out your current insurance info on the patient information form)*

WERE YOU AT FAULT: YES / NO (IF YES, SKIP THE NEXT AT FAULT SECTION)

AT FAULT AUTO INSURANCE INFORMATION (ONLY FILL OUT IF DIFFERENT FROM ABOVE AUTO INSURANCE INFO.)

NAME OF THE PERSON AT FAULT: \_\_\_\_\_

POLICY NUMBER: \_\_\_\_\_ CLAIM NUMBER: \_\_\_\_\_

NAME OF AUTO INSURANCE COMPANY: \_\_\_\_\_

MAILING ADDRESS OF AUTO INSURANCE: \_\_\_\_\_

NAME OF ADJUSTER: \_\_\_\_\_ PHONE: \_\_\_\_\_

HAVE YOU RECEIVED AUTHORIZATION FOR TREATMENT? YES / NO

DO YOU AUTHORIZE OUR OFFICE TO RELEASE MEDICAL INFORMATION TO THIS AUTO CARRIER? YES / NO