



CENTRE OF PHYSICAL REHABILITATION

2301 COIT RD SUITE B
PLANO, TEXAS 75075
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FAX (972) 599-2323

MOTOR VEHICLE ACCIDENT PATIENT INFORMATION SHEET

Patient Name: _____

Address: _____ City: _____ State: _____

DOB: _____ Phone: _____ Gender: _____ Last 4 Digits of SN: _____

Person to Contact in Case of Emergency: _____

Phone: _____ Relationship: _____

MOTOR VEHICLE ACCIDENT INSURANCE INFORMATION (Required Information)

Employer: _____ Phone: _____

Address: _____ City: _____ State: _____

W/C Insurance Company Name: _____ Phone: _____

Address: _____ City: _____ State: _____

Claims Adjustor: _____ Phone: _____ Claim #: _____

Pre-Authorization Company: _____ Phone: _____

Fax Number: _____ Billing Company: _____

Address: _____ Phone: _____

Physician's Name: _____

Address: _____ City: _____ State: _____ Zip Code: _____

I Authorize the provider to provide treatment and authorize that all insurance benefits be paid directly to the provider. I also give the provider authorization to release my personal and medical information to my employer, insurance company, or attorney for the purpose of obtaining payment. I also validate that all the information provided is true, and correct.

Patient Signature: _____ Date: _____