Automobile/Personal Injury Check List

Date: ________________

Patient: ____

Insured: ____

Date of Injury: ____

Insurance Company Name & Address (Not Agency)

____

____

____ Phone: ________________

Adjustor: ____ Fax: ________________

Claim #: ____

Policy #: ____

Attorney Name & Address

____

____

____ Phone: ________________

Health Insurance Name & Address

____

____

____ Phone: ________________

ID#: ________________________ Group #: ________________

I understand that I am directly and fully responsible for all medical services rendered to me.

Patient Name (Please Print) ____

____

Patient Signature Date

Avenues of Health
2415 Hennepin Avenue South
Minneapolis, MN 55405

Dr. Bob Shepherd
Dr. Paula Allenburg
Dr. Jane Green