ACCIDENT INJURY CLINIC

Patient Registration

PATIENT INFORMATION			
Patient Name		DOB	☐ M ☐ F
Address		SSN	
City		State	Zip
Driver's License No.	State	Home Phone	
Email Address		Cell Phone	
Primary Care Physician		Phone	
Emergency Contact		Phone	
How did you hear about Texas Injury Clinic?			

EMPLOYER INFORMATION		
Company	Phone	
Address	Fax	
City	State	Zip
Supervisor's Name	Reported to Supervisor? ☐ Yes ☐ No	
Medical Rep	Phone	
Job Description		

GUARANTOR - RESPONSIBLE PARTY		
Insured	DOB	☐ M ☐ F
Home Phone	SSN	

INJURY INFORMATION	
Date of Injury	Type of Injury: ☐ Motor Vehicle ☐ Work ☐ Sports ☐ Other
Would you like help finding an attorney? ❑ Yes ❑ No	

INSURANCE INFORMATION		
Company	Claim #	
Address	Group #	
City	State	Zip
Adjuster	Phone	
	Fax	

ATTORNEY INFORMATION		
Name	Phone	
Address	Fax	
City	State	Zip
Do you have an accident report? ❑ Yes ❑ No		

I AUTHORIZE MY INSURANCE BENFITS TO BE PAID DIRECTLY TO ACCIDENT INJURY CLINIC. I UNDERSTAND THAT I AM FINANCIALLY RSPONSIBLE FOR ANY BALANCE. I AUTHORIZE ACCIDENT INJURY CLINIC OR MY INSUANCE COMPANY TO RELEASE ANY INFORMATION REQUIRED TO PROCESS MY CLAIM.

Signature of Patient / Legal Guardian and Relationship to Patient

Date

Printed Name of Patient / Legal Guardian