Account#__________________

FAMILY PRACTICE ASSOCIATES
PATIENT INFORMATION MOTOR VEHICLE ACCIDENT ONLY

FIRST NAME:______________________MIDDLE NITIAL:________LAST NAME:____________________________

SEX: MALE / FEMALE DATE OF BIRTH:______________AGE______SS#________________________________

MAILING ADDRESS:____

PHYSICAL ADDRESS:____

HOME PHONE:____________________CELL PHONE:________________WORK PHONE:______________________

EMPLOYER:___________________________SPOUSES NAME:____

MARTIAL STATUS: MARRIED DIVORCED LEGALLY SEPERATED SINGLE WIDOW

STUDENT: FULL TIME PART TIME NAME AND ADDRESS OF SCHOOL:_____________________________

EMERGENCY CONTACT (NOT RESIDING WITH YOU)____

ADDRESS AND PHONE# OF EMERGENCY CONTACT____

DATE OF ACCIDENT:_____________________**TYPE OF INJURY**:_______________________________________

RESPONSIBLE PARTY INFORMATION
(For dependent children, please fill in information on both parents)

FULL NAME:______________________________RELATION TO PATIENT:_______SS#:_________________________

MAILING ADDRESS:____

HOME PHONE:__________________CELL PHONE:___________________WORK PHONE:____________________

EMPLOYER
NAME:____

EMPLOYER ADDRESS:____

BY SIGNING THIS FORM, I AM AWARE THAT FAMILY HEALTH PRACTICE ASSOCIATES WILL NOT BE FILING THE MOTOR VEHICLE ACCIDENT WITH ANY INSURANCE COMPANY OR THIRD PARTY. ANY CHARGES INCLUDED FOR THIS MOTOR VEHICLE ACCIDENT WILL BE SELF PAY, WITH CHARGES DUE AT TIME OF SERVICE.

SIGNATURE OF PATIENT OR IF MINOR LEGAL
GUARDIAN:____DATE:____________________